

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00804

850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10000</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13000 N. Green Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Heppert</u> Middle <u>META</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22 - 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bremen, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Richter</u>		14. MOTHER'S MAIDEN NAME <u>Adella Cordia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7-0-700000 11202</u>	
17. INFORMANT <u>J. W. Bird</u> Address <u>11202 N. 9th St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>years</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mos</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>✓</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/16/58</u> to <u>1/14/58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>1/16/58</u> , and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring</u> DATE SIGNED <u>1/14/58</u>	
PHYSICIAN'S NAME (Type) <u>J. W. BIRD, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki</u> ADDRESS <u>1756 Pennsylvania Ave NW, Washington, DC</u>		24a. REC'D BY REGISTRAR <u>✓</u> DATE <u>1/15/58</u>	
24b. REGISTRAR'S SIGNATURE <u>✓</u>			

BUREAU V. S.

JAN 16 1958

RECEIVED

851
CERTIFICATE OF DEATH

00805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 210 E. Melbourne	
3. NAME OF DECEASED (Type or print) First Emma Middle Streng Last Ager		4. DATE OF DEATH Month Jan. Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustave Streng		14. MOTHER'S MAIDEN NAME Caroline Laupp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Thelma Ager		Address 210 E. Melbourne St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, abdominal 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Aneurysm, aorta, ruptured			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1955 , to Jan 26, 1958 , that I last saw the deceased alive on Jan 26, 1958 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. W. Smith M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4601 16th St NW Wash. D. C. 1/27/58	
PHYSICIAN'S NAME (Type) A. W. SMITH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-58	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. N. W. Wash. D. C.	
24a. REC'D BY REGISTRAR Feb 3 '58		24b. REGISTRAR'S SIGNATURE Deal	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 3 1958

RECEIVED

852

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Red Wing 60 X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 411 8th Street	
3. NAME OF DECEASED (Type or print) First August Middle Herman Last ANDRESEN		4. DATE OF DEATH Month January Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 October 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Congressman		10b. KIND OF BUSINESS OR INDUSTRY Politics	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oley Andresen		14. MOTHER'S MAIDEN NAME Anna Lunke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) Hypertensive Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 48 days 3 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrointestinal bleeding due to duodenal ulcer 11-27-57			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 December , 19 57 , to 14 January , 19 58 , that I last saw the deceased alive on 14 January , 19 58 , and that death occurred at 12:06 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thirl Jarrett		ADDRESS (Street, city or town, state) DATE SIGNED 1-14-58	
PHYSICIAN'S NAME (Type) Thirl Jarrett, Capt, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-58	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Red Wing Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's, 1736 Penn Ave., Washington, D. C.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PAU V. B.

JAN 17 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

853

CERTIFICATE OF DEATH

00807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>7902 Glenbrook Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>E.</u> Last <u>ANDREWS</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mch. 18, 1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Frederick C. Stang</u>				14. MOTHER'S MAIDEN NAME <u>Mosburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>E.C. Andrews-Item# 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2</u> , 19 <u>57</u> , to <u>JAN. 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN. 28</u> , 19 <u>58</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M. Bowden</u>				ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u>		DATE SIGNED <u>1-28-58</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. BOWDEN</u>				<u>Cherry Chase, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

854 CERTIFICATE OF DEATH

Reg. Dist. No.

00808

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 305 North Frederick Ave,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EVA DUTROW AYTON				4. DATE OF DEATH Jan. 25 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26 1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Walter Dutrow				14. MOTHER'S MAIDEN NAME Jane Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hersey D. Aytton		Address Same A^o I	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Hypertensive & Arteriosclerotic HD DUE TO 18 yrs (c)						INTERVAL BETWEEN ONSET AND DEATH 10d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus cerebral vascular accidents						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 19 56 to Jan 25 19 58 that I last saw the deceased alive on Jan 25 19 58 , and that death occurred at 8:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Bowditch Hunter Jr.		M.D. 809 Viersville Rd.		ADDRESS (Street, city or town, state) Rockville, Md.		DATE SIGNED Jan 25, 19 58	
PHYSICIAN'S NAME (Type) G. Bowditch Hunter Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 28 58	22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 29 '58	24b. REGISTRAR'S SIGNATURE W. H. Search		

CERTIFICATE OF DEATH

Name of deceased		Date of death		Place of death	
JAMES WILLIAM		JAN 29 1958		DETROIT, MICH.	
Sex		Age		Race	
Male		25		White	
Marital status		Cause of death		Manner of death	
Single		Heart disease		Natural	
Occupation		Education		Religion	
None		High School		Catholic	
Usual residence		Date of birth		Place of birth	
Detroit, Mich.		JAN 4 1933		DETROIT, MICH.	
Usual occupation		Date of last illness		Place of last illness	
None		JAN 25 1958		DETROIT, MICH.	
Name of physician		Signature of physician		Signature of registrar	
None		[Signature]		[Signature]	

BUREAU V. 1

JAN 29 1958

RECEIVED

855

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Ralph Middle Anderson Last Baldwin		4. DATE OF DEATH Month January Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 9-1885
9 AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper for landscape gardener		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harvey G. Baldwin		14. MOTHER'S MAIDEN NAME Emma Strawn	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 577-24-2701	
17 INFORMANT Mrs Ruth Baldwin, Comus, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis with congestive hrt fail. DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Dec. 1957 to 15 Jan. 1958 , that I last saw the deceased alive on 14 Jan 1958 , and that death occurred at 1:45 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Gordon M. Smith M.D. Barnesville, Md. 15 Jan 58 PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/58	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Md	
23 FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville Md		24a REC'D BY REGISTRAR DATE JAN 17 '58	
24b REGISTRAR'S SIGNATURE W. B. Hilton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 19 1950

RECEIVED

809

CERTIFICATE OF DEATH

Reg. Dist. No. 00810

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE		d. STREET ADDRESS 2309 LINDEN LANE	
3. NAME OF DECEASED (Type or print) MRS. SARA ANN BARBER		4. DATE OF DEATH JAN. 18 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/65
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN A. TURNER	
14. MOTHER'S MAIDEN NAME CATHERINE STUART		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO NONE		17. INFORMANT Mr. Gilbert W. Barber, Tompkinsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) None			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) He had an upper respiratory infection			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 5 1958 to Jan 18 1958 , that I last saw the deceased alive on 1/17/58 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas H. Walston		ADDRESS (Street, city or town, state) 500 Underwood St. N.W. Washington, D.C.	
PHYSICIAN'S NAME (Type) Chas H. Walston		DATE SIGNED 1/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/21/58	22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY	22d. LOCATION (City, town or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR JAN 23 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE W. B. Humphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 12 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

810

CERTIFICATE OF DEATH

00811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>3813 Kelsey St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Babe Ethel Bechtel</u>		4. DATE OF DEATH Month Day Year <u>January 6 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5 1938</u>
9. AGE (In years last birthday) <u>19</u>		IF UNDER 1 YEAR: Months Days Hours Min <u>8 56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Albert Bechtel Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mabel Kinsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Winston E. Cochran</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-5-</u> , 19 <u>58</u> , to <u>1-6-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-6-</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D. 927 Pershing Dr., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. ...</u> ADDRESS <u>Washington Sanitarium & Hospital</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>			

BUREAU V. S.

JAN 9 1958

RECEIVED

856

CERTIFICATE OF DEATH

00812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>7107 45th St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA VIRGINIA BELT</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>1-4-1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas West</u>				14. MOTHER'S MAIDEN NAME <u>Caroline R. Shanks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>SON</u> Address <u>5103 Danbury Rd. Beth.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage of Rt Cerebral Artery</u> <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>25 Jan. 1958</u> to <u>26 Jan. 1958</u> , that I last saw the deceased alive on <u>26 Jan. 1958</u> , and that death occurred at <u>6:21 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave. Md.</u>				DATE SIGNED <u>26 Jan 58</u>			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u>							
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Humphrey</u>				ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

JAN 8 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

857

CERTIFICATE OF DEATH

00813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SLACK SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2204 COLSTON DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William E. Gladstone Bishop</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-11 1898</u>	
9. AGE (In years last birthday) <u>69 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISION TRAFFIC MGR.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISION TRAFFIC MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANADIAN NAT</u>		11. BIRTHPLACE (State or foreign country) <u>NOVA SCOTIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>SON-IN-LAW</u> <u>THOMAS N. ZAUER</u> Address <u>KENSINGTON 4402 EVELIT ST</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None of the above listed</u> (c) <u>Coronary atherosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>1 da.</u> <u>3 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1/2/58</u> 19 , to <u>1/26/58</u> 19 , that I last saw the deceased alive on <u>1/26/58</u> 19 , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.				ADDRESS (Street, city or town, state) <u>900-17th St. N.W. Wash. D.C.</u> DATE SIGNED <u>1/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>1/29/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>Jan 28 1958</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 28 1958
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

811

00814

CERTIFICATE OF DEATH

Item 3 Film G225 2/14/58 GTE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>				d. STREET ADDRESS <u>6403 Eastern Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>C.</u> Middle <u>William Charles</u> Last <u>Bladen</u>				4. DATE OF DEATH <u>January</u> Month <u>25</u> , Day <u>19</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not employed</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Adam Thomas Bladen</u>			14. MOTHER'S MAIDEN NAME <u>Frances Ida Norton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>578-24-9039</u>		17. INFORMANT <u>Mrs Florence Walters, 314 Faragut St NE</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>							<u>24 hrs</u>
44 <u>or</u> DUE TO <u>Cardio-Vascular -Renal Disease</u>							--
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension, Generalized</u>							--
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, exogenous</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 26, 1956</u> , to <u>1-25-</u> <u>1958</u> , that I last saw the deceased alive on <u>1-25-</u> <u>1958</u> , and that death occurred at <u>2:20P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel A. Hillman</u>				ADDRESS (Street, city or town, state) <u>249 Missouri Avenue, N.W.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Cornell St NW DC</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

JAN 19 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

812 CERTIFICATE OF DEATH

00815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>19 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>of Alice Blorstad</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 28, 1958</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. <u>19</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Odd Palmer Blorstad</u>				14. MOTHER'S MAIDEN NAME <u>Alice Perry Damon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory obstruction</u> DUE TO <u>Congenital stenosis of trachea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>and esophagus -</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polyhydramnios</u> <u>Permaternity</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 12</u> Month, Day, Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/28</u> , 19 <u>58</u> , to <u>1/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Chinn</u>				ADDRESS (Street, city or town, state) <u>925 Potomac Drive Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M. D.</u>				DATE SIGNED <u>1/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare M.D.</u>				ADDRESS <u>Washington Sanitarium & Hosp.</u>		24a. REC'D BY REGISTRAR <u>FILED</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chinn</u>			

8 1953

RECEIVED

858

CERTIFICATE OF DEATH

00816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4822 Leland Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAY Middle Woodin Last BOND				4. DATE OF DEATH Month Jan. Day 28 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR: Months 0 Days 4 Hours Min. 	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyrus Woodin				14. MOTHER'S MAIDEN NAME Lura Kiesler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Everett Hassler Address same as 2d				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JAN 27, 1958 to JAN 28, 1958 that I last saw the deceased alive on JANUARY 27, 1958 , and that death occurred at 1:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8025 ABERDEEN RD Bethesda, Md DATE SIGNED 1/28/58							
ACTUAL SIGNATURE Delwitt E. DeLaughter M.D. 8025 ABERDEEN RD Bethesda, Md							
PHYSICIAN'S NAME (Type) DELWITT E. DELAUGHTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Transit		22b. DATE THEREOF 1/30/58		22c. NAME OF CEMETERY OR CREMATORY Homesdale		22d. LOCATION (City, town, or county) (State) Homesdale, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Address Ethesda, Maryland				24a. REC'D BY REGISTRAR JAN 31 '58		24b. REGISTRAR'S SIGNATURE Delwitt E. DeLaughter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 31 1959

RECEIVED

813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN TB <u>5 hrs - 36 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>4 x 1</u>	
3. NAME OF DECEASED (Type or print) <u>Bo by girl Bruce</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/38</u>
9. AGE (In years last birthday) <u>20</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A Boune</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Tolon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother's chest</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prenatality</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-26</u> , 1958, to <u>1-26</u> , 1958, that I last saw the deceased alive on <u>1-26</u> , 1958, and that death occurred at <u>20h</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.		<u>1-27-58</u>	
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D.</u> <u>927 Pershing Dr. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Hare, MD</u> ADDRESS <u>Wash. San. & Hospital, Takoma Park, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Cochran</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

00818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BURTENVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>7943 ORCHID ST. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>-</u> Last <u>BRICK</u>		4. DATE OF DEATH Month <u>JAN</u> - Day <u>25</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-4-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>-</u>	
14. MOTHER'S MAIDEN NAME <u>-</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>		17. INFORMANT <u>GOLDA BECKER - 7943 ORCHID ST NW DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart disease</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1.5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept 10, 1957</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 25, 1958</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>		ADDRESS (Street, city or town, state) <u>7743 Alaska Ave NW Washington, DC</u>	
DATE <u>1/25/58</u>		DATE SIGNED <u>1/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 26 '58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217 5th NW</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Goldberg</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 29 1959

BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00819

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville. Rural</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Travilla Rd.</u>		d. STREET ADDRESS <u>Travilla Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel Remus Briggs</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1883</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James . Briggs</u>	
14. MOTHER'S MAIDEN NAME <u>Drusilla Snyder</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest C. Briggs, Gaithersburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead at home sitting in living room chair</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan. 28, 1958</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 30 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Ernest C. Gartner</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 17 1953

RECEIVED
JAN 17 1953

861

CERTIFICATE OF DEATH

00820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>7034 Strathmore St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Anna</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1907</u>
9. AGE (In years lost birth day) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin McKinney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cully</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Russell Brown</u>	
17. INFORMANT <u>Russell Brown</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesario</u> DUE TO <u>111X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epid. mixed Carcinoma of Cervix uteri</u> DUE TO (c) <u>7 mos</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour <u>11</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>58</u> , to <u>1/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>58</u> , and that death occurred at <u>10</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick K. Y. Donn</u> M.D.		ADDRESS (Street, city or town, state) <u>1835 I St., N.W.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Frederick K. Y. Donn</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REGISTRY REGISTER DATE	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

862 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00821

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. R-27 Montg. Co.		e. STREET ADDRESS Md R-27 Montg. Co.	
3. NAME OF DECEASED (Type or print) Della A. Burdette		4. DATE OF DEATH Month Jan Day 28 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1891
9. AGE (In years last birthday) 66 yrs		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Watkins		14. MOTHER'S MAIDEN NAME Fidelia Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO --	
17. INFORMANT Bates E. Watkins, Monrovia, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) drowning Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Found dead in bath tub		INTERVAL BETWEEN ONSET AND DEATH Found dead in bath tub	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Found dead in partly filled bath tub of her home		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1958	
22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edm L. Moleworth		24a. REC'D BY REGISTRAR Damascus, Md.	
24b. REGISTRAR'S SIGNATURE DATE FEB 3 '58			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00822

-863

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. R -27 Montg. Co.</u>		d. STREET ADDRESS <u>Md. - 27 Montg. Co.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert E. Burdette</u>		4. DATE OF DEATH <u>Jan. 29, 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perry G. Burdette</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Becraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-32-3116</u>	
17. INFORMANT <u>Amos D. Burdette, Gaithersburg, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>774X</u> DUE TO <u>hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Found hanging in basement of his home</u>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20c. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>Jan. 29, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 31, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Clagettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. McLean Jr.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
ADDRESS <u>Damascus, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Adams</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1953

WAVE

864

CERTIFICATE OF DEATH

Reg. Dist. No.

00823

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boys - RFD</u>		c. LENGTH OF STAY IN 1b <u>77 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Boys - RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>D</u> Last <u>BYRD</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 - 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Own farm - Active</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John B. Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Deirs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>615-36-5767</u>	
17. INFORMANT <u>Mrs Joseph Byrd, Boys - RFD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion</u> <u>4437</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic congestive heart failure</u> DUE TO <u>Hypertensive cardiovascular disease</u> (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 year</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Feb., 1948</u> to <u>8 Jan., 1958</u> , that I last saw the deceased alive on <u>6 Jan., 1958</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. <u>DAWSONVILLE P.O. Boyd, Md</u>		DATE SIGNED <u>1/8/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/10/58</u>	<u>Monocacy</u>	<u>Beallville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>	
ADDRESS <u>Burrowsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Hilton</u>	

BURMAN V. S.

1941

RECEIVED

865

CERTIFICATE OF DEATH

00824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9304 Lindale Drive		d. STREET ADDRESS 9304 Lindale Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marion Billington Carter		4. DATE OF DEATH Month Day Year Jan. 26 19 58	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Govt.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi O. Billington		14. MOTHER'S MAIDEN NAME Marion Loomis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Sidney F. Malone		Address 9304 Lindale Dr. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 2, 19 50 to January 26, 19 58 , that I last saw the deceased alive on January 24, 19 58 , and that death occurred at 1:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle		M.D. 5009 Del Ray Ave Bethesda, Md. DATE SIGNED 1/26/58	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		5009 Del Ray Avenue, Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town or county) (State) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Anderson		24a. REC'D BY REGISTRAR JAN 28 '58	
ADDRESS 1756 Pennsylvania Ave NW, Washington, DC		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. Y.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00825

866

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germananton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Germananton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martin</u> First <u>Sutton</u> Middle <u>Catton</u> Last		4. DATE OF DEATH <u>January</u> Month <u>9-</u> Day <u>1958</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN-15-1893</u> AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>public school</u>	
11. BIRTHPLACE (State or foreign country) <u>Blanco Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stonger Catton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Burkett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>yes 1918</u>		16. SOCIAL SECURITY NO <u>229-03-8986</u>	
17. INFORMANT <u>Myrtle M. Catton</u> Address <u>Germananton, Md. Route 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthenia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan-7-</u> , 1958, to <u>Jan-9-</u> , 1958, that I last saw the deceased alive on <u>January-8-</u> , 1958, and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7 - Brooks Avenue</u> DATE SIGNED <u>William C. Miller</u>			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William C. Miller</u>		<u>Gaithersburg, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Chathamville Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer C. Jackson</u> ADDRESS <u>Gaithersburg Md</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 13 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 18 1900

RECEIVED

867

CERTIFICATE OF DEATH

00826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wyatt Middle Carl Last Chandler		4. DATE OF DEATH Month January Day 28 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Law Enforcement	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Chandler		14. MOTHER'S MAIDEN NAME Liza Towns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 194X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) TRACHEAL OBSTRUCTION DUE TO (c) GIANT CELL CARCINOMA OF THYROID			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 2 WEEKS 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 2, 1958 to January 28, 1958 that I last saw the deceased alive on January 28, 1958 and that death occurred at 4:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/28/58			
ACTUAL SIGNATURE Richard K. Shaw M.D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) High Point NC
23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER		24a. REC'D BY REGISTRAR 3 158	
24b. REGISTRAR'S SIGNATURE PI			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950

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868

CERTIFICATE OF DEATH

Reg. Dist. No. 110827

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last CLARK				4. DATE OF DEATH Month Jan. Day 11 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Johnson				14. MOTHER'S MAIDEN NAME Anna V. Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Miss Elsie Clark Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH, 2 weeks 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/15 , 19 57 to 1/11/58 , 19 58 , that I last saw the deceased alive on 1/11/58 , 19 58 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 1/12/58							
ACTUAL SIGNATURE Patriok C. Jameson M.D.				PHYSICIAN'S NAME (Type) Patriok C. Jameson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/58		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring.		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 '58	
24b. REGISTRAR'S SIGNATURE W. H. ...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 1 Day		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 1007 Baltimore, Rd.	
3. NAME OF DECEASED (Type or print) First Robert Joseph Middle CLARK Last CLARK		4. DATE OF DEATH Month January Day 31 Year 19 58	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 January 1958
9 AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Joseph John CLARK		14. MOTHER'S MAIDEN NAME Phyllis Marie ROSSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (Father) Joseph J. CLARK (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 769.6 Respiratory Insufficiency DUE TO (b) Pulmonary Hyaline Membrane Disease DUE TO (c) 12 hrs.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth of diabetic mother		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 January 19 58 to 31 January 19 58 , that I last saw the deceased alive on 31 January 19 58 , and that death occurred at 8:55 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED			
ACTUAL SIGNATURE Adam G. Thorp, Jr. M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. P. Humphrey, 7550 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR FEB 6 '58	
24b. REGISTRAR'S SIGNATURE Asst. Dir.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

00830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>804-Maplewood Ave.</i>				d. STREET ADDRESS <i>7106 Central Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jessie Eyton CLARKE</i>				4. DATE OF DEATH Month <i>JAN</i> Day <i>24</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/2/1874</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Japan</i>	
						12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Latham Owen Eyton</i>				14. MOTHER'S MAIDEN NAME <i>Kiyo Hijikata</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i></i> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Sylvia MacKinnon. Daughter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma of left lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>1/24</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1/20</i> , 19 <i>58</i> , and that death occurred at <i>5:10 p. m.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William D. Aud</i>		M.D.		ADDRESS (Street, city or town, state) <i>9026 Cleveland Rd Silver Spring, Md</i>		DATE SIGNED <i>1/24/58</i>	
PHYSICIAN'S NAME (Type) <i>William D. Aud</i>							
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-27-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tom Lee & Sons</i>				ADDRESS <i>300 4th N. E.</i>		24a. RECEIVED BY REGISTRAR DATE <i>JAN 29 58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. S. Smith</i>			

RECEIVED

JAN 29 1939

BUREAU V. S.

871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN IB 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 401 Westover	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Elizabeth Last Cook		4. DATE OF DEATH Month 1 Day 3 Year 19 58	
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-80
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired-	
11. BIRTHPLACE (State or foreign country) Ludow, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Jewett		14. MOTHER'S MAIDEN NAME Grace Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elmer A. Cook Address (Same) Husband			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PHLEBOTROMBOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subendocardial myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Dec. 1957 to JAN 3, 1958 , that I last saw the deceased alive on 1/2 , 19 58 , and that death occurred at 5:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles J. Savarese, Jr. M.D.		ADDRESS (Street, city or town, state) 4890 Battery Lane Bethesda, Md.	
PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, JR.		DATE SIGNED 1/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-7-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Norfolk, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 7 '58	
		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

815

CERTIFICATE OF DEATH

Reg. Dist. No.

00832

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. + Hospital</u>				e. STREET ADDRESS <u>11113 Midvale Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Ann</u> Last <u>Cooley</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1958</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Samuel M. Iles</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Odden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the gallbladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>475.1 Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 10, 1957</u> to <u>Jan. 12, 1958</u> , that I last saw the deceased alive on <u>Jan. 12, 1958</u> , and that death occurred at <u>6:25 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>929 Pershing Drive, Silver Spring, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>				M.D. <u>929 Pershing Drive, Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>				<u>929 Pershing Drive, S. S.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Church</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

JAN 14 1938

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled in by the funeral director, page 1. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9 Film G225 1-30-58 et

CERTIFICATE OF DEATH

872

00833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Edlecoff</u> Last <u>Corbett</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 21-1876</u>
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Abraham Corbett</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Rebecca Leaman, Germantown, Md.</u>	
17. INFORMANT <u>Rebecca Leaman, Germantown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 1, 1957</u> , to <u>Jan 21, 1958</u> , that I last saw the deceased alive on <u>Jan 21, 1958</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Germantown, Md.</u> DATE SIGNED <u>1-21-58</u>			
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D.		PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wmest O. Martner.</u> ADDRESS <u>Hagersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Wmest O. Martner.</u>

BUREAU V. S.

JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

873

CERTIFICATE OF DEATH

Reg. Dist. No.

00834

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 73 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rena Middle Ardell Last Cramton				4. DATE OF DEATH Month January Day 12 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mender		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	
11. BIRTHPLACE (State or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Samuel Bingham				14. MOTHER'S MAIDEN NAME Nellie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO 199.21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic malignant Carcinoid Tumor 18 mo DUE TO (c) 18 mo INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 31, 1957 , to January 12, 1958 , that I last saw the deceased alive on January 12, 1958 , and that death occurred at 1:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/12/58 SIGNATURE Thomas N. Lynn, Jr. M. D. National Institutes of Health PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr., M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 1/13/58				22b. DATE THEREOF 1/13/58		22c. NAME OF CEMETERY OR CREMATORY Lawrence	
22d. LOCATION (City, town, or county) Massachusetts				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR DATE JAN 17 1958		24b. REGISTRAR'S SIGNATURE Archibald	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>56 Silver Spring,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hosp.</u>				d. STREET ADDRESS <u>8902 Bradford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ISRAEL</u> Middle <u>(NONE)</u> Last <u>DANKER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-9-1885</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>MR. BERNARD (VMN) Danker</u>				14. MOTHER'S MAIDEN NAME <u>Michelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MR. George Steiner - Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <u>+12.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div> DUE TO (b) <u>atherosclerosis</u> DUE TO (c) _____ </div> </div> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> <div style="width: 15%; border-left: 1px solid black; padding-left: 5px;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:00</u> a.m. <u>1-6</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u>				DATE SIGNED <u>1-6-58</u>			
EXAMINER'S NAME (Type) <u>Bernard H. Ostrow</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-8-58</u>		<u>Hebrew Friendship</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>				ADDRESS <u>2100 Euteria Pl</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be ordered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 9 1958

RECEIVED

817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mt. ...</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hosp</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
f. STREET ADDRESS <u>1 10312 Kensington PKY</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Davis</u>				4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William P. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Alice Trovathan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>Washington Sanatorium & Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO <u>Kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>probably</u> <u>years</u> <u>probably</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 1957</u> , to <u>January 4, 1958</u> , that I last saw the deceased alive on <u>January 4, 1958</u> , and that death occurred at <u>6:48 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Arnon H. Traum</u> M.D. <u>8237 Georgia Ave - Silver Spring Md. Jan 5 '58</u>							
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u> <u>8237 Georgia Ave Silver Spring Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
<u>TRANS. & BURIAL</u>				<u>1/7/58</u>			
<u>PINEVIEW CEMETERY</u>				<u>ROCKY MOUNT, NORTH CAROLINA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS							
<u>Warner E. Humphrey</u> <u>SILVER SPRING, MD.</u>							
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE							
<u>DATE JAN 8 '58</u> <u>Red Leach</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958

RECEIVED

870

CERTIFICATE OF DEATH

Reg. Dist. No.

00829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3921 Newline Road</u>	
3. NAME OF DECEASED (Type or print) <u>Ruby E. Clark deLashmuth</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reuben Clark</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sen-Wibbian P deLashmuth</u>		Address <u>6040 Marian Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, lungs and left chest</u> DUE TO <u>110X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma left breast</u> DUE TO <u>Wail</u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos + 2 1/2 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial degeneration, diffuse</u> (b) <u>Pleural Effusion, bilat</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> to <u>Jan 31</u> , 1958, that I last saw the deceased alive on <u>Jan 31</u> , 1958, and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Stewart C. Clark</u> M.D. <u>3921 Ingomar X Rd</u>		<u>1/31/58</u>	
PHYSICIAN'S NAME (Type) <u>Stewart C. Clark</u> M.D.		<u>Wash 15 20</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/3/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>G. H. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOSEPH V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

874

CERTIFICATE OF DEATH

Reg. Dist. No.

00837

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 78 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 13009 Disney Lane	
3. NAME OF DECEASED (Type or print) First Belle Middle Esther Last Disney		4. DATE OF DEATH Month January Day 15 Year 1958	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1898
9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby sitter & Homemaker own home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Coar		14. MOTHER'S MAIDEN NAME Mary E. Burton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 29, 1957 to January 15, 1958 , that I last saw the deceased alive on January 15, 1958 , and that death occurred on 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/15/58 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Roger Lester		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Roger Lester, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/18/58	22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY	22d. LOCATION (City, town, or county) (State) BURTONSVILLE, Montgomery Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edward L. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR DATE JAN 20 '58		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 2 3 4 5 6 7 8 9 10 11 12

1 2 3 4 5 6 7 8 9 10 11 12

1 2 3 4 5 6 7 8 9 10 11 12

818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b D O A d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6208 42nd Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hanora Theresa Donoghue				4. DATE OF DEATH Month Day Year January 23 19 58			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-84	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWf		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Maloney				14. MOTHER'S MAIDEN NAME Mary Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from December 1957 to January 1958 that I last saw the deceased alive on January 23, 1958 , and that death occurred at 10:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019 University Boulevard, Silver Spring, Maryland DATE SIGNED 1/23/58 ACTUAL SIGNATURE Boris Rabkin PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD				
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.			24a. REC'D BY REGISTRAR DATE JAN 27 1958	24b. REGISTRAR'S SIGNATURE Q. L. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 27 1900

RECEIVED

CERTIFICATE OF DEATH

00839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>2859 MILLS AVENUE N.E.</i>			
3. NAME OF DECEASED (Type or print) <i>Patrick Joseph Dougherty</i>				4. DATE OF DEATH <i>January 2 1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 16, 1880</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. Post Light</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Patrick</i>				14. MOTHER'S MAIDEN NAME <i>Bridget Hamilton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Margaret Dietrich</i> Address <i>Green Acres, Md. 5224 Baltimore Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart disease</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>490x</i> <i>Subar pneumonia</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1/1/58</i> , 19 <i>58</i> , to <i>1/2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1/2</i> , 19 <i>58</i> , and that death occurred at <i>8:30 P.</i> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>6450 Wisconsin Ave, Bethesda, Md.</i> DATE SIGNED							
ACTUAL SIGNATURE <i>Dr. Joseph Kenrick</i> M.D.							
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH KENRICK</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/6, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town or county) (State) <i>Colmar Manor, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home</i> ADDRESS <i>Mt. Rainier, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 8 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Redman</i>		

TO SURVIVAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. NAVY

1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00840

876

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 mos. 22 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1745 "N" Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last Gessner Harrison ECHOLS			4. DATE OF DEATH Month Day Year January 20 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 November 1902	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Virginia	
				12. CITIZEN OF WHAT COUNTRY? U.S.	

13. FATHER'S NAME William H. ECHOLS	14. MOTHER'S MAIDEN NAME Elizabeth HARRISON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - -	16. SOCIAL SECURITY NO. Unknown
17. INFORMANT (Wife) Mrs. Anne Y. ECHOLS (Same As #2)	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, large bowel & metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 6 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 Oct. 19 57, to 20 Jan. 19 58, that I last saw the deceased alive on 20 January 19 58, and that death occurred at 1:42 P.M. from the causes and on the date stated above	
ACTUAL SIGNATURE <u>R. J. Mc Carthy</u> PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u>	ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>1-21-58</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-21-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) 4000 Suitland Rd. S.E. Wash. D.C.
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23. REGISTER'S SIGNATURE <u>R. J. Mc Carthy</u>	ADDRESS U.S. Naval Hospital, Bethesda, Md.	24a. REC'D BY REGISTRAR JAN 22 '58	24b. REGISTRAR'S SIGNATURE <u>Arch...</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 11

MI 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

40841

877

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Washington b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 District of Columbia d. STREET ADDRESS 840 Yuma Street S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Honesto (n) ENCELAN		4. DATE OF DEATH Month Day Year January 16 1958	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 February 1900
9. AGE (In years last birthday) 57 yrs		IF UNDER 1 YEAR Months Days Hours M n	IF UNDER 24 HRS Months Days Hours M n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) Filipino Islands
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME ENCELAN, Pedro	
14. MOTHER'S MAIDEN NAME De MONTRADE, Apleza		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WWI	
16. SOCIAL SECURITY NO. 552141835		17. INFORMANT Address (Wife) Rosario L. ENCELAN (Same as #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 445X Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4930 About 3-10 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 December, 1957 , to 16 January, 1958 , that I last saw the deceased alive on 16 January, 1958 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling U.S. Naval Hospital, NNMC, Bethesda Md. 1-16-58			
ACTUAL SIGNATURE C. U. Shilling		M.D. U.S. Naval Hospital, NNMC, Bethesda Md.	
PHYSICIAN'S NAME (Type) C. U. SHILLING		LT MC USN U. S. Naval Hospital, Bethesda Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Chambers 517 11th St. S.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1958

878

CERTIFICATE OF DEATH

Reg. Dist. No.

00842

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 80 days		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Pennsylvania		b. COUNTY Northumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trevorton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 800 Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Charles		Middle Franklin		Last Evans		4. DATE OF DEATH Month January		Day 22		Year 1958	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1898		9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months 59		IF UNDER 24 HRS Days 22		Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Attendant			10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Evans					14. MOTHER'S MAIDEN NAME Alice Koons						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes			16. SOCIAL SECURITY NO. 207-03-9499		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant carcinoma primary in duodenum											
DUE TO (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left femur; anthraco-silicosis; diabetes											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 904.9											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 3, 1957 to January 22, 1958 that I last saw the deceased alive on January 22, 1958 and that death occurred at 6:30 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Samuel Charache M.D.						ADDRESS (Street, city or town, state) The Clinical Center			DATE SIGNED 1/22/58		
PRINTED NAME (Type) Samuel Charache, M. D.						The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/58		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows		22d. LOCATION (City, town, or county) (State) Shamokin, Pennsylvania					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland						24a. REC'D BY REGISTRAR DATE JAN 24 '58		24b. REGISTRAR'S SIGNATURE W. J. - educh			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

JAN 21 1953

RECEIVED

819

CERTIFICATE OF DEATH

00843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7606 Wildwood Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Isadore Theodore Feldmann				4. DATE OF DEATH Month Day Year Jan. 1 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Feldmann				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) Yes WW-2		16. SOCIAL SECURITY NO.		17. INFORMANT Address David Feldmann -1438 University Lane, Hyatts., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia 102.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Basaloid carcinoma of the thyroid gland 1 year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) adenocarcinoma of rectum - Carcinoma, Metastatic						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1952 , to Jan 1 , 1958, that I last saw the deceased alive on Jan 1 , 1958, and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7733 ALASKA AVE. WASH DC DATE SIGNED Jan 1 1958							
ACTUAL SIGNATURE Robert L. Krichmar M.D.				PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR WASHINGTON, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. Danzansky & Sons 3501 14th St., N.E.				24a. REC'D BY REGISTRAR DATE 1958		24b. REGISTRAR'S SIGNATURE H. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. GOVERNMENT

1984

879

CERTIFICATE OF DEATH

00844

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>20 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>5820 4th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Elizabeth</u> Last <u>FINE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 January 1958</u>		9. AGE (In years last birthday) <u>ys</u>	IF UNDER 1 YEAR Months <u>20</u> Days <u>hours</u>	IF UNDER 24 HRS Hours <u>20</u> Min. <u>hours</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leo Norman FINE</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie LICHTENBERG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Leo Norman FINE (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fetal Atelectasis</u> DUE TO (c) <u>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>3 January 1958</u> to <u>4 January 1958</u> , that I last saw the deceased alive on <u>4 January 1958</u> , and that death occurred at <u>6:05 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>1-7-58</u>							
ACTUAL SIGNATURE <u>Adam G. Thorp Jr.</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Adam G. Thorp, Jr. LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-8-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Danzansky & Son, 3501 14th Street, N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>1-7-58</u>		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 9 1938

RECEIVED

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORA ANNABELL Middle SOUDER Last FLAX				4. DATE OF DEATH Month JAN. Day 29 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/90	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN SOUDER				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 577-22-9628		17. INFORMANT Mr. Morris Flax, 9709 Forest Grove Drive Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c) arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 13 hrs. 6 months 10 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1952 , to 1-29 , 1958 , that I last saw the deceased alive on 1-28 , 1958 , and that death occurred at 8:15 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-29-58							
ACTUAL SIGNATURE Lester S. Blumenthal M.D.							
PHYSICIAN'S NAME (Type) LESTER S. BLUMENTHAL							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/31/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner L. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 31 58	
				24b. REGISTRAR'S SIGNATURE G. L. Smith			

BUREAU OF

JAN 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4- may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>11,906 Valleywood Drive</u>		d. STREET ADDRESS <u>11906 VALLEYWOOD DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROL</u> <u>JEAN</u> <u>FOOSE</u>		4. DATE OF DEATH Month Day Year <u>JAN</u> <u>20</u> <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 AUG 57</u>
9. AGE (In years last birthday) yrs <u>0</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u> IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Thomas Foose</u>		14. MOTHER'S MAIDEN NAME <u>Ann L. Bridges</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT Address <u>Mr. Edward T. Foose, 11,906 Valleywood Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LARYNGO-TRACHEITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 17, 1958</u> , to <u>JAN 19, 1958</u> , that I last saw the deceased alive on <u>JAN 19, 1958</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10,011 Ga. Ave., Silver Spring, Md.</u> DATE SIGNED <u>1/20/58</u>			
ACTUAL SIGNATURE <u>Henry W. Stout</u>		M.D. <u>10,011 Ga. Ave., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Outman</u>

BUREAU V. S.

AN 1960

RECEIVED

882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9920 Georgia Ave.		d. STREET ADDRESS 9920 Georgia Ave.	
3. NAME OF DECEASED (Type or print) First Ethel Middle Leonard Last Fox		4. DATE OF DEATH Month Jan. Day 22 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/98
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME S. Leonard		14. MOTHER'S MAIDEN NAME Lelia Camack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nathan D. Booth		Address 9920 Georgia Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute right heart failure DUE TO (b) chronic cardiac decompensation DUE TO (c) Rheumatic heart disease			INTERVAL BETWEEN ONSET AND DEATH 72 hrs 3 1/2 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 20, 1954 to Jan 22, 1958 , that I last saw the deceased alive on Jan 22, 1958 , and that death occurred at 7:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel B. Washington		ADDRESS (Street, city or town, state) 6234 Sacre Hwy Wash DC	
PHYSICIAN'S NAME (Type) Daniel B. Washington M.D.		DATE SIGNED 1/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	24b. REGISTRAR'S SIGNATURE DATE 2-4-58

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00848**

820

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkman Park, Md.</u> <u>Silver Spring, Md.</u> c. LENGTH OF STAY IN 1b <u>DoA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>12303 Charles Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Edward Fox</u> First Middle Last			4. DATE OF DEATH <u>January 27 1958</u> Month Day Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-08</u>	9. AGE (In years last birthday) <u>49</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Fox</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Geesling</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>U.S. Army</u>		16. SOCIAL SECURITY NO. <u>577-05-6013</u>		17. INFORMANT <u>Mr. Lowell Kilker</u> <u>4414 Clearfield Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, ant. descending branch left coronary artery</u> (b) <u>Pulmonary edema, massive</u> (c) <u>few minutes</u> DUE TO <u>few minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m. <u>1-27 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>			
20f. (City or town) <u>Silver Spring, Md.</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>1-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkman Cem</u>		
22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>			22e. (State) <u>Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>			24. REC'D BY REGISTRAR <u>1400 Chapman St</u>				
24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			DATE <u>JAN 30 '58</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, file the certificate with the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 2 1908



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00849

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maine b. COUNTY Hancock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Nov 1957 to 27 Jan 1958	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7400 Fairfax Road		e. STREET ADDRESS XXXXXXX Street XXXXXXX Pretty Marsh Road XXXXXXX Town: Mount Desert XXXXXXX XXXX XXXX	
3. NAME OF DECEASED (Type or print) SAMUEL Mickle FOX, Jr.		4. DATE OF DEATH Month January Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Engineer, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Plastic Industry	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mickle Samuel A. Fox, Sr.		14. MOTHER'S MAIDEN NAME Richards Elizabeth Newbold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO. 161-01-6408	
17. INFORMANT Dr. Samuel M. Fox, III-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) Mucoid carcinoma of caecum		INTERVAL BETWEEN ONSET AND DEATH 1 minute 4 days 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): General debility and inanition			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED Jan. 27, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/27/1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24. REC'D BY REGISTRAR DATE JAN 28 '58	
25. REGISTRAR'S SIGNATURE <i>W. J. Adams</i>			

MEDICAL CERTIFICATION

BUREAU X. B.

JAN 8 1938

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 40850

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>3 wks.</u>		d. STREET ADDRESS <u>4527 Nebraska Ave. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens San.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie Fulwider Galbraith</u>		4. DATE OF DEATH Month Day Year <u>Jan. 9, 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/1872</u>
9. AGE (In years last birthday) <u>85 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilson Fulwider</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blades</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>San. records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>443X</u> DUE TO (b) <u>Hypertention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of rt hip 11/17/57</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURNING, CREMATION, REMOVAL (Specify) <u>Burned</u>		22b. DATE THEREOF <u>1-9-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Indeapolis Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Fulwider Han</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>	
ADDRESS <u>4812 Bacon NW Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00851

885

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
c. LENGTH OF STAY IN 1b 4 years		d. STREET ADDRESS 8808 WALNUT HILL ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8808 WALNUT HILL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE MAE GARDELLA		4. DATE OF DEATH JANUARY 29 19 58	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23, 1882
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES THOMAS		14. MOTHER'S MAIDEN NAME LAURA CLOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WALLIS H. GARDELLA, 9624 BEXHILL DR., KENSINGTON, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Disturbance 4 + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis with Hypertension DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1940 , to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonfield St. Silver Spring, Md	
DATE SIGNED 1/29/58			
PHYSICIAN'S NAME (Type) W. B. WARDROP			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 31, 1958	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JAN 31 '58		24b. REGISTRAR'S SIGNATURE Wm. E. Humphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. B.

JAN 31 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00852

886

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>YENSINGTON GARDENS SANITARIUM</u>				d. STREET ADDRESS <u>1353 LONGFELLOW ST.</u>			
3. NAME OF DECEASED (Type or print) <u>ELLEN</u> First Middle Last <u>GOLDEN</u>				4. DATE OF DEATH <u>Jan 23 1958</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 22 1860</u> 9. AGE (In years last birthday) <u>97</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Y. STATE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USH</u>	
13. FATHER'S NAME <u>BENJAMIN GOLDEN</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HILLBRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>NURSING Home Records 3000 M^e CONNS AVE</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>year?</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 21, 1955</u> , to <u>Jan 23, 1958</u> , that I last saw the deceased alive on <u>Jan 20, 1958</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil P. Campbell</u>				ADDRESS (Street, city or town, state) <u>Kennewater Road Ok</u> DATE SIGNED <u>1/23/58</u>			
PHYSICIAN'S NAME (Type) <u>NEIL P. CAMPBELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TYOGA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SAYRE PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Gowers Sons</u> ADDRESS <u>1756 Pa. Ave. Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1900

RECEIVED

821

CERTIFICATE OF DEATH

Reg. Dist. No.

00853

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Sanitarium + Hospital</u>				d. STREET ADDRESS <u>4411 Gladwyne Drive</u>			
3. NAME OF DECEASED (Type or print) <u>INA</u> First <u>KRATZ</u> Middle <u>P.</u> Last <u>Goodwin</u>				4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-06</u>	
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK (OFFICE) TREASURY DEPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>KANSAS</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
13. FATHER'S NAME <u>CHARLES E. PINGREE</u>				14. MOTHER'S MAIDEN NAME <u>Amy KRATZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>CHART + Pt.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>200.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pituitary cell Sarcoma</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH, <u>Immediate</u> <u>3 1/2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>9/18/1955</u> to <u>1/23/1958</u> , that I last saw the deceased alive on <u>1/23/1958</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.				ADDRESS (Street, city or town, state) <u>8801 Colesville Road, Silver Spring, Md.</u>			
DATE SIGNED <u>1/24/58</u>							
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 5 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00854

FOR STATE
HEALTH DEPT.

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,313 Douglas Avenue		e. STREET ADDRESS 10,313 Douglas Avenue	
3. NAME OF DECEASED (Type or print) Samuel Raymond Graves		4. DATE OF DEATH Month January Day 11 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 11 Days 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant cashier		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis M. Graves		14. MOTHER'S MAIDEN NAME Ethel M. Dove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 579-05-0614	
17. INFORMANT Mrs. Rita H. Graves		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 1/11/58	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wagner & Humphrey		24a. REC'D BY REGISTRAR DATE JAN 14 '58	
24b. REGISTRAR'S SIGNATURE W. J. P. Jones			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1958

RECEIVED

888

CERTIFICATE OF DEATH

Reg. Dist. No.

00855

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 139 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 508 Oronoco Street			
3 NAME OF DECEASED (Type or print) First Florence Middle Joy Last Grigsby				4. DATE OF DEATH Month January Day 26 Year 1958			
5 SEX Female		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 2, 1957	
9. AGE (In years last birthday) 6 yrs		IF UNDER 1 YEAR Months 24 Days 24 Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME Norbert Grigsby				14 MOTHER'S MAIDEN NAME Florence Groham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO None		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia							
7545 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Congestive Heart Failure							
DUE TO							
(c) Congenital Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 12 Hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from September 8, 1957 , to January 26, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John Ross Jr.</i>				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) JOHN ROSS JR., M. D.				DATE SIGNED 1/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/30/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or county) Arlington		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. A. Lewis</i>				ADDRESS Bethesda 14, Maryland		24a. REC'D BY REGISTRAR 6666 6 '58	
				24b. REGISTRAR'S SIGNATURE <i>John Lewis</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1963

RECEIVED

889

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First JACOB Middle EDWARD Last HARMON		4. DATE OF DEATH Month January Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1905
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52	IF UNDER 24 HRS Months 52 Days 52 Hours 52 Min. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Harmon		14. MOTHER'S MAIDEN NAME Ida Heckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic Failure. DUE TO (c) Cirrhosis of the liver			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 1957 to Jan 7, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 4:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE L. I. Leal M.D.			
PHYSICIAN'S NAME (Type) L. I. Leal, M.D., Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24. REC'D BY REGISTRAR DATE JAN 9 58	
24b. REGISTRAR'S SIGNATURE C. J. Leach			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

100-100000

890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virgie Irene Harris</u>		4. DATE OF DEATH Month Day Year <u>Jan 19 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 30-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Brasmus Perry</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Lvely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Archibald L. Harris, Derwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 DAYS</u> <u>10 YEARS</u> <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 26</u> , 1957, to <u>JAN 19</u> , 1958, that I last saw the deceased alive on <u>JAN 16</u> , 1958, and that death occurred at <u>3:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon H. Rosenberger</u>		DATE SIGNED <u>Jan 19, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Gordon H. Rosenberger</u>		ADDRESS (Street, city or town, state) <u>264 SUMMIT ST. GAITHERSBURG, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>	22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Gaithersburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 22 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD V. 1

6

DEAL

CERTIFICATE OF DEATH

00858

Reg. Dist. No.

891

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1hr. 40 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Hatzes		4. DATE OF DEATH Month January Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/58
9. AGE (In years last birthday) yrs. 1 Months 1 Days 40 Min. 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME R. Louis Hatzes		14. MOTHER'S MAIDEN NAME Mary Lou Renaud	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT R. Louis Hatzes		Address Same Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) at birth DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/4/58 , 19 58 , to 1/4/58 , 19 58 , that I last saw the deceased alive on 1/4/58 , 19 58 , and that death occurred at 4:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Yates M.D.		ADDRESS (Street, city or town, state) Olney, Md DATE SIGNED 1/4/58	
PHYSICIAN'S NAME (Type) R. A. Yates, M.D.		Olney, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR 105 24b. REGISTRAR'S SIGNATURE Ed. Mednick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 11 11 11 11

6 6 6 6 6

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, postmark should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00859

892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN IB 5 days 10 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rufus Middle Payne Last Hebron				4. DATE OF DEATH Month January Day 19 Year 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1922	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Wm. Mossberg		11. BIRTHPLACE (State or foreign country) Darnestown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Hebron				14. MOTHER'S MAIDEN NAME Malinda Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 219 124 323		17. INFORMANT Mary Ester Hebron, Wife Address Germantown, Md. Rt. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 5 1/2 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerular nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 58 , to 1/19 , 19 58 , that I last saw the deceased alive on 1/19 , 19 58 , and that death occurred at 9:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4700 Highland Ave Bethesda, Md. DATE SIGNED 1/20/58 ACTUAL SIGNATURE Robert S. Snowden M.D. NAME (Type) Robert S. Snowden							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58		22c. NAME OF CEMETERY OR CREMATORY Poolesville, Md.		22d. LOCATION (City, town, or county) (State) Poolesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE Overman	

BUREAU OF

JAN 18 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS Box 212 - Route 3	
3. NAME OF DECEASED (Type or print) Idella First Henry Last		4. DATE OF DEATH Month 1 Day 15 Year 1958	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1883
9. AGE (In years last birthday) 74 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Martin		14. MOTHER'S MAIDEN NAME Jennie Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Husband Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 586X DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstruction of common duct - biliary calculus 6 days			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Right lower lobe pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 58 , to 1/15 , 19 58 , that I last saw the deceased alive on 1/15 , 19 58 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Robert L. Suovick M.D. 4711 Highland Ave		1/15/58	
PHYSICIAN'S NAME (Type) Bethesda Md.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 1/20/58	22c. NAME OF CEMETERY OR CREMATORY Pleasant View,	22d. LOCATION (City, town, or county) (State) Quince Orchard, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suovick ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 1958	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

8201

10/1/54

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00861

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If instit on Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6907 Wilson Lane		e. STREET ADDRESS 6907 Wilson Lane	
3. NAME OF DECEASED (Type or print) HELEN I. HIGHT		4. DATE OF DEATH Month January Day 31 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/82
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 11 Days 4 Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Washington, D. C.		14. CITIZEN OF WHAT COUNTRY? US	
15. FATHER'S NAME Charles H. Ingram		16. MOTHER'S MAIDEN NAME Charlotte McGill	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. ----	
19. INFORMANT Charles H. Hight-Item# 2		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 1/31/58	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit	22b. DATE THEREOF 2/1/58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Nashville, Tenn.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 3	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. OVERMAN

1915

822

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>6 1/2 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>8208 Roanoke Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jack Canova Hodge</u>		4. DATE OF DEATH Month Day Year <u>January 1 1958</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-11</u>
9. AGE (In years last birthday) <u>46 yrs.</u>		10. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>
13. FATHER'S NAME <u>Salton Hodge</u>		14. MOTHER'S MAIDEN NAME <u>XXXX Mamie Estelle Folker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1933-1938</u>		16. SOCIAL SECURITY NO. <u>272-14-9044</u>	17. INFORMANT Address <u>Hospital Records</u>
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complication of Respiratory Center</u> DUE TO <u>Tracheo-bronchial tumor -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Stage due to Rupture - Congestive Heart Failure</u> (b) <u>Stage due to Rupture - Congestive Heart Failure</u> (c) <u>Stage due to Rupture - Congestive Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			INTERVAL BETWEEN ONSET AND DEATH <u>10-12 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>57</u> , to <u>1/1</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>12/31</u> , 19 <u>57</u> , and that death occurred at <u>2:54 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John T. Lord</u> M.D.		ADDRESS (Street, city or town, state) <u>2025 Eye St NW WASH DC</u> DATE SIGNED <u>1/1/58</u>	
PHYSICIAN'S NAME (Type) <u>John T. Lord</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Campney Silver Spring</u>		24a. REC'D BY REGISTRAR <u>ML</u> DATE <u>1/6/58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within 72 hours after death.

U. S. A.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>		d. STREET ADDRESS <u>325 Potomac St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abel</u> Middle <u>Nora</u> Last <u>Hoffman</u>		4. DAY OF DEATH <u>Jan 4</u>		Month <u>Jan</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17 - '97</u>		9. AGE (In years last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Caterer</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Sam Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Gittleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hosp. record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis with Cardiac Degeneration</u> DUE TO (b) <u>Chronic bronchitis with bronchiectasis</u> DUE TO (c) <u>20 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Sept 27</u> , 19 <u>58</u> to <u>Jan 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Irwin L. Yager</u>		M.D. <u>3055-16th St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN L. YAGER MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. Lebanon Cemetery</u>	
22d. LOCATION (City, town, or county)		(State) <u>Hyattsville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Langensky & Son</u>		ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

VS A15 (4)
15M 9/55

BUREAU A. S.

JAN 7

RECEIVED

895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				c. LENGTH OF STAY IN 1b Home			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS Brooke Road			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Mirah Hopkins				4. DATE OF DEATH Month Day Year January 30 19 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1875		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Snowden				14. MOTHER'S MAIDEN NAME Sally Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Montgomery County General Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 Congestive Heart Failure DUE TO (b) ArterioSclerotic Heart Disease DUE TO (c) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 7 yrs 1 yrs 1 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25 , 19 58 , to 1/30 , 19 58 , that I last saw the deceased alive on 1/25 , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 1/30/58							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D.			
PHYSICIAN'S NAME (Type) C. H. Ligon, M.D.				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/58		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 '58	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be examined within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

188



824

CERTIFICATE OF DEATH

Reg. Dist. No. 00865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Son's Hosp</u>				d. STREET ADDRESS <u>Hall</u>			
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Fietta</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/89</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Smith</u>				14. MOTHER'S MAIDEN NAME <u>Alice Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Illness</u> <u>Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive - Cardiac Failure</u> <u>ASHD</u> (c) <u>Multiple Small Cerebral infarcts</u> <u>IC. climp.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>PM</u>	Month <u>Jan</u>	Day <u>3</u>	Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>Jan 3, 1958</u> , that I last saw the deceased alive on <u>Jan 3, 1958</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond O. Wise</u>				ADDRESS (Street, city or town, state) <u>7600 Arden Ave.</u>		DATE SIGNED <u>1/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Raymond O. Wise</u>				LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bros - Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albeauch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 9 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No. 00866

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. STREET ADDRESS 312 Nimitz Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Roger Francis Howrigan		4. DATE OF DEATH Month Day Year January 8 19 58	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 18-1977
9 AGE (In years last birthday) 81/30 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN	
10b. KIND OF BUSINESS OR INDUSTRY ERCO ENGINEERS		11 BIRTHPLACE (State or foreign country) Vermont	
13. FATHER'S NAME Patrick James Howrigan		14. MOTHER'S MAIDEN NAME Elizabeth Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 101-10-1010	
17. INFORMANT Roger L. Howrigan - Son -		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) PYELONEPHRITIS DUE TO (c) PYELONEPHROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 17, 1957 to 1/8 1958 , that I last saw the deceased alive on 1/8 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE L. I. Leal M.D.		PHYSICIAN'S NAME (Type) L. I. Leal, D. Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/58	22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24. REC'D BY REGISTRAR DATE JAN 13 1958	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Reverend	

BUREAU V. S.

RECEIVED

897

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c LENGTH OF STAY IN 1b 18 MONTHS			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE-2603 Finley Street				e STREET ADDRESS 3603 FINLEY ST.			
3 NAME OF DECEASED (Type or print) MRS. MINNIE KEYES IVEY				4 DATE OF DEATH JANUARY 31, 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MARCH 14, 1872	9. AGE (In years lost birthday) 85	10. IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR Months Days Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES KEYES				14. MOTHER'S MARRIED NAME MINNIE MAY KEYES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT PAULINE IVEY WOODWARD Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIOSCLEROTIC HEART DISEASE (c) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 3 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No.			
20c. TIME OF INJURY Month, Day, Year Hour NONE 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work NO		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE, 1957 to JANUARY, 1958 , that I last saw the deceased alive on JANUARY 29, 1958 , and that death occurred at 7:41 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Belden R. Reap 11502 Branden Ave. DATE SIGNED 1/31/58							
ACTUAL SIGNATURE Belden R. Reap				PHYSICIAN'S NAME (Type) BELDEN R. REAP			
22a. BURIAL, CREMATION, REMOVAL, etc. 2/3/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Stephens Episcopal		22d. LOCATION (City, town, or county) (State) Catlett, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash., D.C.				24a. REC'D BY REGISTRAR FEB 4 '58		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

23

ED 100

898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Oak		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) David Jackson		4. DATE OF DEATH January 18 1958	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1885
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11b. KIND OF BUSINESS OR INDUSTRY Farm	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Jackson		14. MOTHER'S MAIDEN NAME Mary Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579 22 7807	
17. INFORMANT Louise Jackson		Address Silver Spring, Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO Arteriosclerotic Cardiorenal Disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis, Senile Dementia.			INTERVAL BETWEEN ONSET AND DEATH 2 days 1/10/58
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year May 26, 1948 Hour o. m. 19 P. m. 10:20 A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Norbeck (County) RT.1 (State) Md.	
21. I certify that I attended the deceased from May 26, 1948 to January 18, 1958 , that I last saw the deceased alive on January 16, 1958 , and that death occurred at 10:20 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		DATE SIGNED 1/19/58	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/58	22c. NAME OF CEMETERY OR CREMATORY Good Hope,	22d. LOCATION (City, town, or county) (State) Colesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR Jan 23 1958		24b. REGISTRAR'S SIGNATURE John A. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FUREAU V. B.

1908

RECEIVED

899

CERTIFICATE OF DEATH

Reg. Dist. No

00869

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Indian Spring Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Trinidad Middle Munoz Last Jacques		4. DATE OF DEATH Month January Day 3 Year 19 58	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1867
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Refugio Munoz		14. MOTHER'S MAIDEN NAME Nieves Martinez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Miss Ascension Jacques, 15 Indian Spring Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Acute cerebrovascular accident 351X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 10 hrs 1-10 yrs 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Old slip fracture - stairs when ambule			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) (State)	
21. I certify that I attended the deceased from July 1950 , to Jan 3, 1958 , that I last saw the deceased alive on Jan 2, 1958 , and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3000 Conn. Ave. Wash. D.C. DATE SIGNED 1-3-58			
ACTUAL SIGNATURE T. F. McMahon M.D.			
PHYSICIAN'S NAME (Type) Thomas F. McMahon, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/8/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery
22d. LOCATION (City, town, or county) Durango, Colorado		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE T. F. McMahon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

825

CERTIFICATE OF DEATH

110870

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D C</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>14 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
f. STREET ADDRESS <u>3101 Pennsylvania Ave SE</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>Jefferson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1958</u>			
5 SEX <u>fe</u>		6 COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-17-81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William C. Vengel</u>				14 MOTHER'S MAIDEN NAME <u>Elizabeth</u> ——— <u>Unknown to pt.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dated of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <u>Patient - by phone as above</u>							
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro intestinal hemorrhage -</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured esophageal varix</u> DUE TO (c) <u>Cirrhosis of liver -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1/2 day</u> <u>10 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic lymphatic leukemia -</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December, 1956</u> , to <u>January, 1958</u> , that I last saw the deceased alive on <u>January 7, 1958</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.				ADDRESS (Street, city or town, state) <u>2412 Minnesota Ave. S. E.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON, M.D. Washington 20, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Calmar Manor - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lewis Wash. D. C.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. 3.

JAN 12 1950

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and if any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00871

920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
c. LENGTH OF STAY IN 1b 5 years				d. STREET ADDRESS 2826 Munson Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2826 Munson Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFIE Middle CRUM Last JEHLE				4. DATE OF DEATH Month January Day 1 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1881	
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lafayette Crum				14. MOTHER'S MAIDEN NAME Mary Osborne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. Robert A. Jehle, Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myeloiditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 7-8 years 10-12 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 20 March , 19 46 , to 1 Jan , 19 58 , that I last saw the deceased alive on 30 Dec , 19 57 , and that death occurred at 4 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. B. Queen M.D. 7112 Willow Ave ADDRESS (Street, city or town, state) 1 Jan 1958 DATE SIGNED							
PHYSICIAN'S NAME (Type) G. B. Queen, MD Takoma Park, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF Jan. 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Prince George County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS 8434 Ga. Ave., S.S., Md.				24a. REC'D BY REGISTRAR 1303 DATE		24b. REGISTRAR'S SIGNATURE A. H. H. H.	

5 2 1000

100



826

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ellis</u> Middle <u>T</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-04</u>
9. AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hamstead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Washington Sanitarium & Hospital</u>		Address <u>Reag</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive gastrointestinal hemorrhage</u> DUE TO <u>581.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to portal cirrhosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 30, 1957</u> , to <u>Jan 4, 1958</u> , that I last saw the deceased alive on <u>Jan 3, 1958</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elmer Magi M.D.</u>		DATE SIGNED <u>1/4/58</u>	
PHYSICIAN'S NAME (Type) <u>ELMER MAGI</u>		<u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
24a. REC'D BY REGISTRAR		DATE <u>JAN 8 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1958

RECEIVED

827

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
f. STREET ADDRESS <u>4201 Argyle Terrace N.W.</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Emma Zenda Jones</u>				4. DATE OF DEATH Month Day Year <u>Jan 5 1958</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Rece Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Norris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac</u> DUE TO (c) <u>arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 22, 1957</u> to <u>Jan 5, 1958</u> ; that I last saw the deceased alive on <u>Jan 5, 1958</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7733 Alameda Ave. N.W. Wash. D.C.</u> <u>12 28</u>							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/7/58</u>		<u>Parklawn</u>		<u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00874

991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 174 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 8, D.C. d. STREET ADDRESS 1609 22nd Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Javorka Last Jugo		4. DATE OF DEATH Month January Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 21, 1951
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Jugo		14. MOTHER'S MAIDEN NAME Rosanda Marot	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Hematomyositis		INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 mo 20 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bacterial pneumonia bilateral; gastric ulcer		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 19 57 , to January 15 , 19 58 , that I last saw the deceased alive on January 15 , 19 58 , and that death occurred at 11:45 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-15-58			
ACTUAL SIGNATURE Peter T. Rowley M.D. Peter T. Rowley, M. D.		The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-18-58	
22c. NAME OF CEMETERY OR CREMATORY WASH NATH CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		24a. REC'D BY REGISTRAR 1400 Chapin St DATE JAN 17 '58	
24b. REGISTRAR'S SIGNATURE Q. J. Smith			

U.S. AIR FORCE
AN 17 1959
RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 602 South Broadway	
3. NAME OF DECEASED (Type or print) First Nikolay Middle (None) Last Kazimiruk		4. DATE OF DEATH Month January Day 26 Year 19 58	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1888
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11 BIRTHPLACE (State or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Mike Kazimiruk		14. MOTHER'S MAIDEN NAME Dorothy Kazimiruk	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO Unascertainable	
17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Liver due to necrosis of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Upper Gastro-intestinal Hemorrhage from Esophageal Varices. (c) Portal Cirrhosis of Liver			INTERVAL BETWEEN ONSET AND DEATH 11 hrs. 14 hrs. at least 12 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 20, 1958 , to January 26, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 6:54 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas N. Lynn Jr. M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr., M. D.		DATE SIGNED 1/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORY St Andrews	22d. LOCATION (City, town, or county) (State) Greenbelt MD Md
23. FUNERAL DIRECTOR'S SIGNATURE Heavenly Funeral Home		ADDRESS 637 West Blvd.	
24a. REC'D BY REGISTRAR W. J. ...		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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JAN 19 1900

903

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 15 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. ✓							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1828 "Q" Street, S. E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Russell Middle Watson Last KEENEY				4. DATE OF DEATH Month January Day 11 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 December 1897		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman		10b. KIND OF BUSINESS OR INDUSTRY Congressman		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter KEENEY				14. MOTHER'S MAIDEN NAME Kittie WATSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with multiple metastases 1774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 28 December, 1957 to 11 January, 1958 , that I last saw the deceased alive on 11 January, 1958 , and that death occurred at 11:31 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-12-58							
ACTUAL SIGNATURE A. A. Galuszka				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) A. A. GALUSZKA, CAPT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-17-58		22c. NAME OF CEMETERY OR CREMATORY Naplesville Prot. Cemetery		22d. LOCATION (City, town, or county) (State) Naplesville, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th and Mass., Ave., N.W.				24a. REC'D BY REGISTRAR DATE JAN 14 '58		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1958

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00877

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Echo Heights</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5706 Mohican Pl.</u>		e. STREET ADDRESS <u>5706 Mohican Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Joseph Kelley</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1914</u>
9. AGE (In years (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)			

U. S. BUREAU

1907

RECEIVED

828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Truman Almond Kennedy</u>		4. DATE OF DEATH Month Day Year <u>Jan. 20 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Union Representative Retail Clerks</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S. America</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Kennedy</u>		14. MOTHER'S MARDEN NAME <u>Lula Masemer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates at service) <u>Yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart-arterial Shock</u> DUE TO <u>Surgery for Cancer - internal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 months?</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-16</u> , 19 <u>58</u> , to <u>1-20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>58</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John F. Brownberger</u> M.D.		<u>Jan 20 1958</u>	
PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>		<u>Takoma Park - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hume Co.</u>		ADDRESS <u>1-14 St</u>	24a. REC'D BY REGISTRAR <u>Jan 22 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRITISH V. S.

NOV

RECEIVED

905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 20 1/2 yrs.		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Virginia		b. COUNTY Roanoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				d. STREET ADDRESS 321 Berkeley Ave., Va. Heights				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodosia		First Earnest		Middle Kerr		4. DATE OF DEATH Month Jan		Day 21	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1861		9. AGE (In years last birthday) 96	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Abram Moody				14. MOTHER'S MAIDEN NAME America Beckner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 4 x U. I. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c) <i>chronic arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 yr</i> <i>2 yr</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-4</i> , 19 <i>56</i> , to <i>1-21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1-5</i> , 19 <i>58</i> , and that death occurred at <i>7-23</i> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <i>Sarah E. Glover</i>				M.D. <i>4208 Ardenway St Kensington Md</i>					
PHYSICIAN'S NAME (Type) Sarah E. Glover									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-27-58		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) Gaithersburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58		24b. REGISTRAR'S SIGNATURE <i>Reese</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. 3

1939

WACE

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 906
 CERTIFICATE OF DEATH

00880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 12 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS Forest Glenn Castle Inn	
3. NAME OF DECEASED (Type or print) JOSEPH First DOEIX Middle RENO Last KRATZ		4. DATE OF DEATH Month January Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 15, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Painting Contractor (Retired)	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Kratz		14. MOTHER'S MAIDEN NAME Catherine Hilligass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 197-01-1761	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis insufficiency DUE TO 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ? 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 13 , 19 58 , to Jan. 14 , 19 58 , that I last saw the deceased alive on Jan. 14 , 19 58 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird		ADDRESS (Street, city or town, state) Sandy Spring, Maryland	
PHYSICIAN'S NAME (Type) J. W. Bird		DATE SIGNED 1/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/16/58	22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY	22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MONT. CO., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS Silver Spring Md		24a. REC'D BY REGISTRAR DATE JAN 16 '58	24b. REGISTRAR'S SIGNATURE Rehman

BUNNELL V. S.

ALBANY, N. Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NIMC, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Arthur LAMCZYK				4. DATE OF DEATH Month Day Year January 2 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 December 1957	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Everett Eugene LAMCZYK				14. MOTHER'S MAIDEN NAME Virginia LOHMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Everett E. LAMCZYK (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis Fetalis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rh Blood Group incompatibility DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 December, 1957 to 2 January, 1958 , that I last saw the deceased alive on 2 January, 1958 , and that death occurred at 8:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Adam T. Thorp Jr.				M.D. U.S. Naval Hospital, NIMC, Bethesda Md. 1-2-58			
PHYSICIAN'S NAME (Type) Adam T. THORP JR. LT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS 755 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR AN 6 1958	
				24b. REGISTRAR'S SIGNATURE U. N. Hedrick			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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S. A. J. V. S.

N

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00882

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 is to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Johnson Rest Home		2. USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1104 Lancaster Road, d. STREET ADDRESS Takoma Park, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM LAMPTON		4. DATE OF DEATH January 31, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1872
9. AGE (in years last birthday) 85 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 9 Days 25 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Plate printer		11b. KIND OF BUSINESS OR INDUSTRY Printing	
12. CITIZEN OF WHAT COUNTRY? USA		13. BIRTHPLACE (State or foreign country) Cedartown, Georgia	
14. FATHER'S NAME William M. Lampton		15. MOTHER'S MAIDEN NAME Sue Battle	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. Wm. N. Lampton-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction rt. Frontal Lobe 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 12 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral bronchopneumonia			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in his room, striking head on floor or furniture	
20c. TIME OF INJURY Month, Day, Year 7:15 p.m. 1/19/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rest Home		20f. (City or town) (County) (State) Silver Spring, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 2/1/58	
EXAMINER'S NAME (Type) Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/1958	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DA FEB 3	
		24b. REGISTRAR'S SIGNATURE 	



U. S. A.

1950

RECEIVED

909

CERTIFICATE OF DEATH

00883

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 73 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2 USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1609 Parham Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William David Leder				4. DATE OF DEATH Month Day Year January 12th 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 2, 1951	
9. AGE (In years last birthday) 6 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Max Leder				14. MOTHER'S MAIDEN NAME Maxine Rombro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory insufficiency 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Lymphosarcoma, DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from October 31, 19 57 to January 12, 19 58 that I last saw the deceased alive on January 12, 19 58 and that death occurred at 6:45 P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 1-13-58			
ACTUAL SIGNATURE Dane R. Boggs				The National Institutes of Health Bethesda, Maryland			
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58		22c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR 1 4 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1958

BUREAU V. S.

829

CERTIFICATE OF DEATH

00884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				e. STREET ADDRESS <u>1114 Hilltop Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Constance</u> Middle <u>(NMN)</u> Last <u>Latham</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-87</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Menzies</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Hosp Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm R. mid. Cerebral artery</u> DUE TO (b) <u>Arterial Hypertension (Chronic)</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined (years)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>Jan 12, 1958</u> that I last saw the deceased alive on <u>Jan 12, 1958</u> , and that death occurred at <u>10:55 AM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>7835 Eastern Ave</u> DATE SIGNED <u>Jan 12, 1958</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				SILVER SPRING MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arner E. Humphrey</u> ADDRESS <u>Silver Spring, MD</u>				24a. REC'D BY REGISTRAR <u>Jan 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quisenberry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES V. S.

AND

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

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AN 11 1900

1850-1859

911

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 640 Fort Washington Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle Lewis Last LODGE		4. DATE OF DEATH Month January Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 March 1936
9. AGE (In years last birthday) yrs. 21		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Julius Y. LEIBOWITZ		14. MOTHER'S MAIDEN NAME Annette LEWIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) Yes 18 June 1957 to present		16. SOCIAL SECURITY NO. 004-32-8686	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Polomyelitis anterior bulbar 000.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 January 1958 , to 9 January 1958 , that I last saw the deceased alive on 9 January 1958 , and that death occurred at 10:20 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-9-58			
ACTUAL SIGNATURE J. T. Horgan M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) J.T. HORGAN, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-58	22c. NAME OF CEMETERY OR CREMATORY Mount Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) Valhalla, New York
23. FUNERAL DIRECTOR'S SIGNATURE Chambers ADDRESS Chambers, 1400 Chapin St. Washington, D. C.		24a. REC'D BY REGISTRAR DATE 1-9-58	24b. REGISTRAR'S SIGNATURE Atkinson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

912

CERTIFICATE OF DEATH

Reg. Dist. No. 00887

1. PLACE OF DEATH a. COUNTY <u>ALLEN TREMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEN TREMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		d. STREET ADDRESS <u>5708 - 2nd AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Zeller</u> Last <u>Lueffler</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>17,</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hilmandale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Zeller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Raymond M. Christy</u>		Address <u>5503 Christy Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Jan 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>58</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert M. Havell</u> M.D.		ADDRESS (Street, city or town, state) <u>5576 N. Ave. Washington, D.C.</u>	
DATE SIGNED <u>1-18-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert M. Havell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fredericksburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2401-14th St NW</u>	24a. REG. BY REGISTRAR <u>W. C. H. C.</u>
DATE <u>Jan 20 58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

NOV 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
913
CERTIFICATE OF DEATH

00888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived) If institutions, residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHTON</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Belmont NURSING HOME</u>			d. STREET ADDRESS <u>RT #1 Box 203</u>		
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>GANET</u> Last <u>LOWE</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 3, 1883</u>		9. AGE (In years last birthday) <u>75 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOSEPHUA BROWNING</u>			14. MOTHER'S MAIDEN NAME <u>MARY GIBSON</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONL</u>	17. INFORMANT Address <u>400 BEALL AVE. ROCKVILLE, MD.</u> <u>MRS MYRTLE V. FREMEAUX</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>1/10/58</u> , 19 <u>58</u> , to <u>1/11/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/10/58</u> , 19 <u>58</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. W. Bird</u>			ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>		
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>			DATE SIGNED <u>1/11/58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FT. MYER VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co.</u>			ADDRESS <u>517-11 4th St. S.E.</u>	24a. REC'D BY REGISTRAR <u>AN 1 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BUREAU V. S.

JAN 15 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

914 CERTIFICATE OF DEATH

Reg. Dist. No. 40889

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Jackie Middle Lee Last Lowe				4. DATE OF DEATH Month Jan. Day 23 Year 19 58			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 27, 1957		9. AGE (in years last birthday) -- yrs.	IF UNDER 1 YEAR Months 27 Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Olney, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Leroy Lowe				14 MOTHER'S MAIDEN NAME Marie F. Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO ---		17 INFORMANT James Leroy Lowe, Damascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Damascus, Md.		20g. (County) (State)	
21. I certify that I attended the deceased from Jan. 20, 1958 to Jan. 23, 1958 , that I last saw the deceased alive on Jan. 21, 1958 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr M.D.				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 1/24/58	
PHYSICIAN'S NAME (Type) James P. Kerr				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clara L. F. [illegible]				ADDRESS Damascus, Md.		24a REC'D BY REGISTRAR DATE JAN 27 '58	
				24b REGISTRAR'S SIGNATURE [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

NOV 2 1903

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

915

CERTIFICATE OF DEATH

00890
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital				e. STREET ADDRESS 13601 St. Mary's Road			
3. NAME OF DECEASED (Type or print) First Kathleen Middle BROWN Last Lucas				4. DATE OF DEATH Month January Day 10 Year 58			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/10	
9. AGE (In years last birthday) 47 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Monroe Brown Reeves		14. MOTHER'S MAIDEN NAME Martha Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 406-28-6508		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x Inanition DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO None (c) None						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 hrs 18 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12:00 , 19 56 to 1/10 , 19 58 , that I last saw the deceased alive on Jan 10 , 19 58 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Sandy Spring, Maryland			
DATE SIGNED 1/11/58							
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 1/13/58		22c. NAME OF CEMETERY OR CREMATORY MARTINSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MARTINSVILLE, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey, Silver Spring, Md.				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '58	
24b. REGISTRAR'S SIGNATURE [Signature]							

BUREAU V. S.

JAN 12 1926

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00891

Reg. Dist. No.

845

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Manor Country Club</u>		e. STREET ADDRESS <u>4022 WARREN STREET, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>THEODORE NEAL MacKay</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. WAR DEPT.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Miss Rita J. Benoit, 4607 Conn. Ave., N.W. Washington, D.C.</u>	
17. INFORMANT <u>Miss Rita J. Benoit, 4607 Conn. Ave., N.W. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell dead on # 3 Green, Manor Club while playing golf</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan. 18, 1958</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>JAN 23 '58</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Pumphrey</u>	

BUREAU V. 3

1 N 10 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 916 CERTIFICATE OF DEATH

00892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) Maple Lake San. 9810 Georgia Ave. S.W.				d. STREET ADDRESS 1311 Juniper Street, N.W.			
3. NAME OF DECEASED (Type or print) ELLEN First Middle Last				4. DATE OF DEATH JAN Month Day Year 1 19 55			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14 - 1869	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Love			
14. MOTHER'S MAIDEN NAME Ann Ritchie				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) IRELAND			
16. SOCIAL SECURITY NO.				17. INFORMANT Charles M. MacMurray Address Washington D.C. 11 Juniper St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 5 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 27, 1957 , to Jan. 1, 1958 , that I last saw the deceased alive on 1-1- , 19 58 , and that death occurred at 8 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry M. Lowden M.D.				ADDRESS (Street, city or town, state) 5206 NORTHEY DR			
DATE SIGNED 1/1/58				PHYSICIAN'S NAME (Type) HENRY M. LOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/4/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Prince George County, Md.				22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St., N.W.		24a. REC'D BY REGISTRAR AN 6	
24b. REGISTRAR'S SIGNATURE W. H. H. Hines				24c. (City or town)			

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917

CERTIFICATE OF DEATH

Reg. Dist. No.

00893

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>15733 Crawford Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>G</u> Last <u>Maddren</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5, 1875</u>	
9. AGE (In years last birthday) <u>82 1/2</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Geologist, U.S. G.S.</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Maddren</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Annie Geddes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>H. H. Maddres, 424 North Arden Blvd. Los Angeles 4, California</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Obstructive uropathy</u> DUE TO (c) <u>Carcinoma of prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Chronic Myelogenous leukemia</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 January</u> , 19 <u>58</u> , to <u>4 January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 January</u> , 19 <u>58</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 W. Wisconsin Ave Bethesda, Md</u> DATE SIGNED <u>4 Jan 58</u>							
ACTUAL SIGNATURE <u>Edward E. Ferguson</u> M.D.				PHYSICIAN'S NAME (Type) <u>EDWARD E. FERGUSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>'58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1955

U.S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

918

CERTIFICATE OF DEATH

Reg. Dist. No. 00894

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLS CHURCH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>811 Pinewood Terrace</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Bernard Maher</u>		4. DATE OF DEATH Month Day Year <u>Jan 4 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oneida, N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William James Maher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Buens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO <u>?</u>	
17. INFORMANT <u>Mrs W. Bernard Maher</u> Address <u>811 Pinewood Terrace Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, Severe</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation, ileum</u> DUE TO (c) <u>2 day</u> 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4 1958</u> to <u>Jan 4 1958</u> , that I last saw the deceased alive on <u>Jan 4 1958</u> , and that death occurred at <u>10:14 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. NW Wash 15 D.C.</u> DATE SIGNED <u>Jan 4 1958</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		DATE SIGNED <u>Jan 4 1958</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>Jan 4 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>1/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ONEIDA, NEW YORK</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumpfney</u> ADDRESS <u>8454 1/2 Ave SE Wash 15 D.C.</u>		24a. REC'D BY REGISTRAR <u>Jan 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
c. LENGTH OF STAY IN 1b 24 hrs.				d. STREET ADDRESS 240 Washington St., Apt. #5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Mahone				4. DATE OF DEATH Month January Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/58	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
						24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Mahone				14. MOTHER'S MAIDEN NAME Jean Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO.		17. INFORMANT Jean Mahone	
				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Voluntarily DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH One day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-25 , 19 58 , to 1-26 , 19 58 , that I last saw the deceased alive on 26 , 19 58 , and that death occurred at 12:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) Gaithersburg, Md.			
DATE SIGNED 1-27-58							
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.				ADDRESS Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-58		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
				24b. REGISTRAR'S SIGNATURE Robert L. Snodden			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 16 1973

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

830

CERTIFICATE OF DEATH

00896

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington San & Hospital</i>		d. STREET ADDRESS <i>1502 East West Highway</i>	
3. NAME OR (Type or print) <i>May Agnes Maloney</i>		4. DATE OF DEATH <i>1 - 12 - 1958</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 9 - 1932</i>
9. AGE (In years last birthday) <i>26</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Gallagher</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Corcoran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> (c) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>probably</i> <i>years</i> <i>at least</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic - Hypertensive Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov</i> 1957, to <i>January 12, 1958</i> , that I lost saw the deceased olive on <i>January 11</i> 1958, and that death occurred at <i>2:40 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Aaron H. Traum</i> M.D.		ADDRESS (Street, city or town, state) <i>8237 Georgia Ave. Silver Spring, Md</i> DATE SIGNED <i>Jan 12 58</i>	
PHYSICIAN'S NAME (Type) <i>Aaron H. Traum</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Ship-BURIAL</i>		22b. DATE THEREOF <i>Jan. 16, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>HOLY CROSS CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>BROOKLYN, NEW YORK</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i> ADDRESS <i>Silver Spring Md</i>		24a. REC'D BY REGISTRAR <i>DATE 1 4 '58</i> 24b. REGISTRAR'S SIGNATURE <i>W. E. Humphrey</i>	

BUREAU V. S.

APR 14 1928

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00897

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY IN 1b 1 1/2 yrs.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural --- City 13 St. Philomena's Nursing Home			
3. NAME OF DECEASED (Type or print) CHARLES A. MANSFIELD		4. DATE OF DEATH Month Jan. Day 1, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1872
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer --- Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Mansfield		14. MOTHER'S MAIDEN NAME Anne Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-2688	
17. INFORMANT Mrs. Ella Broadhurst		Address 4113 Knowles Ave. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH sudden years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brosch		DATE SIGNED 1-2-58	
EXAMINER'S NAME (Type) FRANK J. BROSCHE		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-4-58	22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR 058 DATE 1-2-58	
24b. REGISTRAR'S SIGNATURE W. Hedrick			

S. A. R. 1911

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1911

CERTIFICATE OF DEATH

921

Reg. Dist. No. ~~XXX~~

215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 1218 Rockville Pike	
3. NAME OF DECEASED (Type or print) First Wilbert Middle Frederick Last MARLOW		4. DATE OF DEATH Month January Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 January 1910
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herford MARLOW		14. MOTHER'S MAIDEN NAME Anna Marie JOACHIM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1927 to 1957		16. SOCIAL SECURITY NO 577 44 9643	
17. INFORMANT (Brother) Clarence E. MARLOW (P.O. BOX 265,)		Address (Landover, Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4:00.1 DUE TO Infarction Myocardium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comp. Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1.5 hrs Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 January 1958 to 26 January 1958 , that I last saw the deceased alive on 26 January 1958 and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Mc Carthy		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 30 58	
24b. REGISTRAR'S SIGNATURE W. J. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1908

RECEIVED
JAN 2 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

922

CERTIFICATE OF DEATH

Reg. Dist. No. 00899

1. PLACE OF DEATH o COUNTY Montgomery o STATE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles , Middle Haviland , Last Matthews			4. DATE OF DEATH Month Jan. Day 8 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3 1865		9. AGE (In years last birthday) 92 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Wesley Matthews			14. MOTHER'S MAIDEN NAME Sharlotte Cromwell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address NE Mrs. Gordon Benson, 1235 Newton St. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that I attended the deceased from 2-9-1955 to 2-8-1958 , that I last saw the deceased alive on 1-6-1958 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William C. Miller M.D. PHYSICIAN'S NAME (Type) William C. Miller 7 Br. Ave Gaithersburg, Md.					
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Jan. 11.58		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
22d. LOCATION (City, town, or county) Unity		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 1958	
24b. REGISTRAR'S SIGNATURE Robert...					

BUREAU V. S.

JAN 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **215**

00900

923

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4107 "W" Street, N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Howard MAY</u>				4. DATE OF DEATH Month Day Year <u>January 23 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 August 1887</u>	
9. AGE (In years last birthday) yrs <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Marine Corps</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William J. MAY</u>				14. MOTHER'S MAIDEN NAME <u>Emma B. WURSTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1915 to 1943</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>(Wife) Mrs. Luella H. MAY (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastasis</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 October 19 57</u> to <u>23 January 19 58</u> that I last saw the deceased alive on <u>23 January 19 58</u> and that death occurred at <u>6:12 A.M.</u> from the causes and on the date stated above. <div style="text-align: right;">ADDRESS (Street, city or town, state) DATE SIGNED</div>							
ACTUAL SIGNATURE <u>R. J. McCarthy</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> 1-23-58			
PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gawler & Sons</u>				ADDRESS <u>1426 Pennsylvania Ave., Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1511 Underwood st., N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Gertrude Last McCarthy				4. DATE OF DEATH Month January Day 22 Year 1958						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22 1889		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael W. Calnan				14. MOTHER'S MAIDEN NAME Isabelle G. Harvey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO None		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Abscess/ Pulmonary tuberculosis 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 6 Months		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant Lymphoma (Suspected because of gross autopsy findings.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from December 30, 1957, to January 22, 1958, that I last saw the deceased alive on January 22, 1958, and that death occurred at 9:55A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/22/58 ACTUAL SIGNATURE Norman H. Bell M.D. National Institutes of Health PHYSICIAN'S NAME (Type) NORMAN H. BELL Bethesda 14, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James T. Ryan, Inc. 317 Pa. Ave., SE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Allen				
DATE JAN 24 '58										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

U. S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

925

CERTIFICATE OF DEATH

00902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 45 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1438 Columbia Road, N.W.			
3. NAME OF DECEASED (Type or print) First Manus Middle Ignatious Last McGowan				4. DATE OF DEATH Month January Day 13 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew McGowan				14. MOTHER'S MAIDEN NAME Annie Farr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no or unknown) No (If yes, give war or date of service)				16. SOCIAL SECURITY NO 577-03-1392		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, ? Septicemia DUE TO Multiple pulmonary abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic Malignant Mixed Tumor of DUE TO Parotid Gland to lymph nodes, adenoma (c) 9 mos. INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 29, 19 57 to January 13, 19 58 , that I last saw the deceased alive on January 13, 19 58 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/13/58 ACTUAL SIGNATURE Peter D. Olch M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Peter D. Olch, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/16/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,				24a. REC'D BY REGISTRAR JAN 15 58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1900

RECEIVED

831

CERTIFICATE OF DEATH

Reg. Dist. No. 00903

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		d. STREET ADDRESS <u>14 Crescent Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Elwin</u> Last <u>McNeill</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-77</u>
9. AGE (In years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>u.s.a.</u>	
13. FATHER'S NAME <u>Alfred McNeill</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington San & Hosp Records - 7600 Carroll Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 42 yrs. DUE TO (b) <u>Old Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/3</u> , 19 <u>58</u> , to <u>1/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>58</u> , and that death occurred at <u>1:50 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave.</u> DATE SIGNED <u>1/5/58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>		<u>Takoma Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. ...</u> ADDRESS <u>254 ...</u>		24. REC'D BY REGISTRAR <u>...</u> DATE <u>JAN 7 58</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 N. Van Buren St</u>		e. IS RE INTERMENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell McKinley Meade</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>2</u> - Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-98</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>M.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>N.S.C.</u>	
13. FATHER'S NAME <u>George W. Mead</u>		14. MOTHER'S MARRIED NAME <u>Rose Rozier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Russell Campbell - Son of Deceased</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) stating the underlying cause lost. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Snowden</u>		24a. REC'D BY REGISTRAR <u>JAN 7 1958</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

T. DEPUTY MEDICAL EXAMINER. This certificate should be filled within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. STONE

10-21

926

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 18 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. STREET ADDRESS 11806 Grand View Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harriet Middle Virginia Last MEHOVES		4. DATE OF DEATH Month January Day 6 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 July 1899
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lee C. HUMPHRIES		14. MOTHER'S MAIDEN NAME Harriet Ann SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Son) John Herman MEHOVES (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 December, 19 57 , to 6 January, 19 58 , that I last saw the deceased alive on 6 January, 19 58 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin Plaut		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-6-58	
PHYSICIAN'S NAME (Type) Martin Plaut, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-9-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. REC'D BY REGISTRAR 1-10-58	24b. REGISTRAR'S SIGNATURE Alb. Couch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN - 9 - 1939

RECEIVED

832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>18315 Garland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>(Unnamed)</u> Middle <u>Infant</u> Last <u>Boy Miller</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-58</u>
9. AGE (In years last birthday) <u>35</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William David Miller, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Estelle Plant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother's hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - at 22 wks. gestation</u> 774x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cause unknown</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:55 P.M. 1-11-58</u> to <u>3:30 P.M. 1-11-58</u> , that I last saw the deceased alive on <u>1-11-58</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D.		ADDRESS (Street, city or town, state) <u>2600 Carroll Ave. Takoma Park 12, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D.</u>		DATE SIGNED <u>1-13-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-16-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u> ADDRESS <u>Wash. San. & Hospital</u>		24a. REC'D BY REGISTRAR <u>JAN 20 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. S. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1908

RECEIVED

927 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4804 Somerset Road	
3 NAME OF DECEASED (Type or print) First Clarence Middle William Last Miller		4. DATE OF DEATH Month January Day 11, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1905
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Miller		14. MOTHER'S MAIDEN NAME Martha Orndorff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-8000	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, massive, left. DUE TO (b) Acute Myelocytic Leukemia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 7 hrs. 2 - 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 9, 19 58 , to January 11, 19 58 , that I last saw the deceased alive on January 11, 19 58 , and that death occurred at 2:30 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sherman Weissman</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) SHERMAN WEISSMAN, M. D.		DATE SIGNED 1/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1-14-58	22c. NAME OF CEMETERY OR CREMATORY 77 Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Bladensburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		24a. REC'D BY REGISTRAR 5881 Cleveland Ave	24b. REGISTRAR'S SIGNATURE <i>W.W. Chambers</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1952

RECEIVED
NOV 15 1952

833

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>3606 Everhart St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. CAMILLE MARIE MOORE</u>				4. DATE OF DEATH Month Day Year <u>1-19 1958</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-21</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>Filippo Anthony Capone</u>				14. MOTHER'S MAIDEN NAME <u>Maria Grazia Morfesi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>577-28-9401</u>		17. INFORMANT Address <u>As Chmt - Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>54-00</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chondrosarcoma of the jaw</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec 1957</u> to <u>Jan-19 1958</u> that I last saw the deceased alive on <u>Jan-19 1958</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Isidore Shulman</u> M.D. <u>9-15-1958 L. W.</u> PHYSICIAN'S NAME (Type) <u>Isidore Shulman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Humphrey</u>				ADDRESS <u>Silver Spring, Md</u>		24. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. E. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

JAN 23 1958

RECEIVED

928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Weldon Last Morton				4. DATE OF DEATH Month January Day 27 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tipple Foreman				10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George R. Morton				14. MOTHER'S MAIDEN NAME Hettie Withrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stokes-Adams Attack							
DUE TO 411X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis							
DUE TO (c) Rheumatic Heart Disease, Inactive							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Esophagitis and Gastritis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 2, 19 58 , to January 27, 19 58 , that I last saw the deceased alive on January 27, 19 58 , and that death occurred at 1:45 p.m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1:45 p.m.							
ACTUAL SIGNATURE Louis Gillespie, Jr. M.D. The Clinical Center							
PHYSICIAN'S NAME (Type) LOUIS GILLESPIE M.D. National Institutes of Health							
Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-30-58		Blacks Chapel cemetery		Camden on Gauley	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Deaf Funeral Home 4812 Haddon Rd				24a. REC'D BY REGISTRAR DATE FF '3 '58		24b. REGISTRAR'S SIGNATURE Discharge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. C.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00910

929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring				c. LENGTH OF STAY IN 1b I Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) Marilee Nurseing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES First ARTHUR Middle MULLICAN Last				4. DATE OF DEATH Month January Day 10 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5 1863	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Gen. Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Mulligan				14. MOTHER'S MAIDEN NAME Rachel Ricketts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give date of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas T. Mulligan, Derwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) L.V.A. (multiple over period of 14 days) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosed arteries in coronary DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from April 2, 1957 , to Jan 10, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John S. Rogers M.D.				ADDRESS (Street, city or town, state) Silver Spring Md.			
PHYSICIAN'S NAME (Type) John S. Rogers				DATE SIGNED 1958 January 10 1958			
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF Jan. 12 1958		22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 1958	
24b. REGISTRAR'S SIGNATURE							

RECEIVED

JAN 14 1958

BUREAU V. S.

930

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		d. STREET ADDRESS 225 Watson Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Matthew Middle Mansfield Last NEELY		4. DATE OF DEATH Month January Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 November 1874
9 AGE (In years last birthday) yrs 83		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Senator		10b. KIND OF BUSINESS OR INDUSTRY Politics	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Alfred NEELY		14. MOTHER'S MAIDEN NAME Harriette MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, Spanish American		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Official Navy Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Prostate with metastasis to bones and lungs 177X DUE TO (b) metastasis to bones and lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 20 months
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from 3 September, 19 57 , to 18 January, 19 58 , that I last saw the deceased alive on 18 January, 19 58 , and that death occurred at 10:09 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Thirl E. Jarrett U.S. Naval Hospital, Bethesda, Md. 1-18-58			
ACTUAL SIGNATURE Thirl E. Jarrett M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Thirl E. Jarrett, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF 1-22-58	22c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Fairmont, West Virginia
23 FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR DATE Jan 22 58
		24b REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1901

RECEIVED
JAN 10 1901

931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 518 South Payne Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beatrice Middle (None) Last Neidich		4. DATE OF DEATH Month January Day 1 Year 19 58	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1913
9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morris Weinberg		14. MOTHER'S MAIDEN NAME Dora Weinberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 057-16-8299	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic Carcinoma to Left Lung. DUE TO (c) Carcinoma of Left Breast.		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 23, 19 57 , to January 1, 19 58 , that I last saw the deceased alive on January 1, 19 58 , and that death occurred at 12:03 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/1/58 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Allen Goodman M.D.			
PHYSICIAN'S NAME (Type) ALLEN GOODMAN, M. D.			
22a. BURIAL, CREMATION, or other (Specify) Burial	22b. DATE THEREOF 1/2/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		24a. REC'D BY REGISTRAR 1958	
ADDRESS 3501 14th St., N.W.		24b. REGISTRAR'S SIGNATURE W. H. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

932

CERTIFICATE OF DEATH

00913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7701 EASTERN AVENUE		d. STREET ADDRESS 7701 EASTERN AVENUE	
3. NAME OF DECEASED (Type or print) First HOPE Middle WINDSOR Last NICHOLS		4. DATE OF DEATH Month JAN. Day 29 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1907
9. AGE (In years last birthday) yrs. 50		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WINDSOR		14. MOTHER'S MAIDEN NAME ANNA HOPE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT ROY NICHOLS		Address 7701 EASTERN AVE	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory obstruction DUE TO 18 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic Carcinoma in lungs 6+ mo. DUE TO (c) Carcinoma of breast - left 4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/2/58 , 19 58 , to 1/29/58 , that I last saw the deceased alive on 1/22/58 , and that death occurred at 1:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. P. McNeill M.D.		ADDRESS (Street, city or town, state) 7600 Carroll Ave DATE SIGNED 1/30/58	
PHYSICIAN'S NAME (Type) W. P. McNeill		Takoma Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/31/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24. REC'D BY REGISTRAR Washington, D.C. 24b. REGISTRAR'S SIGNATURE FEB 4 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1908

RECEIVED

933

CERTIFICATE OF DEATH

00914

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE Virginia b COUNTY Scott			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN It 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d STREET ADDRESS Route #1, RFD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Peggy Middle Gertrude Last Nichols				4. DATE OF DEATH Month January Day 29 Year 1958			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 17, 1950		9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry K. Nichols				14. MOTHER'S MAIDEN NAME Mildred Hickam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Idiopathic Hypertension + DUE TO Coronary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from January 26, 1958 , to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 10:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/29/58							
ACTUAL SIGNATURE Carlos R. Lombardo M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M. D.							
22a. BURIAL CREMATION, Burial-Transit		22b. DATE THEREOF 1/30/58		22c. NAME OF CEMETERY OR CREMATORY Gate City		22d. LOCATION (City, town, or county) (State) Gate City, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE FEB 3 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1958

DEAD

931 CERTIFICATE OF DEATH

00915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove				c. LENGTH OF STAY IN TB 50 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 3 Gaithersburg			
d. STREET ADDRESS Rt. 3 Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clifford Middle N. Last Nicholson				4. DATE OF DEATH Month Jan. Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13 1888	
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ruben M. Nicholson				14. MOTHER'S MAIDEN NAME Florence E Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215.20.8988		17. INFORMANT Mrs. Barbara Nicholson Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart failure DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 1 month 2 yrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1940 to Jan. 24, 1958 last saw the deceased alive on Jan. 23, 1958 , and that death occurred at 26 N. Summit Ave. Gaithersburg, Md. ADDRESS (Street, city or town, state) DATE SIGNED Jan. 24, 1958							
ACTUAL PHYSICIAN'S NAME (Type) William A. Linthicum				M.D. 26 N. Summit Ave. Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26 58		22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pray W. Barber ADDRESS Laytonville. Md.				24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

935

CERTIFICATE OF DEATH

Reg. Dist. No. 00916

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6810 Georgia St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WENDELL LOVELESS NIELSEN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative Officer Fed. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Utah</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Brian NIELSEN</u>	
14. MOTHER'S MAIDEN NAME <u>LOVELESS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>550-05-2872</u>		17. INFORMANT <u>Wife - Mrs. Elizabeth Nielsen</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 30</u> , 1954, to <u>Jan 3</u> , 1958, that I last saw the deceased alive on <u>Jan 3</u> , 1958, and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave</u> DATE SIGNED <u>15 Jan 58</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		<u>BETH. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.) TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1 1913

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00917

936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
f. STREET ADDRESS 5002 Danbury Court				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ellen Middle Patricia Last O'Brien				4. DATE OF DEATH Month January Day 8 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1940	
9. AGE (In years last birthday) 17 yrs		IF UNDER 1 YEAR Months 7 Days 7		IF UNDER 24 HRS. Hours 7 Min 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James C. O'Brien				14. MOTHER'S MAIDEN NAME Doris Malinka			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest							
DUE TO 057.0							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningococcus Meningitis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 3 minutes							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from January 7, 1958 to January 8, 1958 that I last saw the deceased alive on January 8, 1958 , and that death occurred at 10:10 a.m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/8/58							
ACTUAL SIGNATURE Ernest R. Simon M. D.				The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) ERNEST R. SIMON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR MAN 13 '58		24b. REGISTRAR'S SIGNATURE <i>W. Branch</i>	

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JAN 19 1911

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00918

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montgomery Co. Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>6 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2300 Blueridge Drive</u>				d. STREET ADDRESS <u>2300 Blueridge Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Anthony OLDERSHAW</u>				4. DATE OF DEATH Month Day Year <u>January 13 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 November 1957</u>		9. AGE (in years last birthday) yrs. <u>1</u> Days <u>16</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John B. OLDERSHAW</u>				14. MOTHER'S MAIDEN NAME <u>Carol Bromann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) John B. Oldershaw (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>(Found dead in Bed)</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>				24a. RECEIVED BY REGISTRAR <u>Jan 14 58</u>		24b. REGISTRAR'S SIGNATURE <u>Cliff</u>	
R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.							

RECEIVED
JAN 14 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00919

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please
explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1701 Dennis Ave</u>		d. STREET ADDRESS <u>1701 Dennis Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>CARVEL</u> Last <u>Caine</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1902</u>
9. AGE in years (or birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Lab.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN Nelson Caine</u>		14. MOTHER'S MAIDEN NAME <u>Essie Jane Dice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>WW #2 578-10-7674</u>	
17. INFORMANT <u>Francis Caine - Son or Son 2</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>shot gun wound</u> (c) <u> </u> DUE TO stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>self inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-16 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

JAN 21 1958

W. A. RYAN

JAN 21 1958

RECEIVED
JAN 21 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>302 Northwest Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Adelaide</u> Last <u>Parkhurst</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-78</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired-hswf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Reinmiller</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Rein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner & Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reber</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. I.

JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 939 2-10-58 at

939

CERTIFICATE OF DEATH

Reg. Dist. No.

00921

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>Barbara</u> Last <u>PAULEY</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George Riehn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Alex Thatt</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> 4 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 28, 1955</u> , to <u>Jan 30, 1958</u> , that I last saw the deceased alive on <u>JAN 24, 1958</u> , and that death occurred at <u>3:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>DeWitt E. DeLauter</u> M.D. <u>8225 HARBORDEEN RD</u> <u>JAN 31, 1958</u>							
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLauter</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Knollwood Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Cleveland Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph H. Harrison 1756 Pa. Ave. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN V. S.

W. R. 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

940

CERTIFICATE OF DEATH

00922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN lb 8 hrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				d. STREET ADDRESS 4408 HEWITT AVENUE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle LODGE Last PAXSON				4. DATE OF DEATH Month JAN. Day 21 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/11/99	
9. AGE (In years last birthday) 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST (District Mgr. Peoples Drug)		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ROBERT SCOTT PAXSON				14. MOTHER'S MAIDEN NAME ANNIE LODGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 214-03-8235		17. INFORMANT Address Mrs. Margaret A. Paxson, 4408 Hewitt Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 hours 4-5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1936 to Jan 21 1958 , that I last saw the deceased alive on Jan 21 1958 , and that death occurred at 4:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 837 Bonfant St. Silver Spring, Md. DATE SIGNED W.B. Wardrop md.							
ACTUAL SIGNATURE W.B. WARDROP MD. M.D.				PHYSICIAN'S NAME (Type) W.B. WARDROP MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Wanner & Humphrey				24a. REC'D BY REGISTRAR ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE DATE JAN 23 '58	

BUREAU V. S.

NOV 19 1908

RECEIVED

941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights		c. LENGTH OF STAY IN 1b 16 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6409 Dahlonge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUCILLE Middle PELLEU Last PELLEU		4. DATE OF DEATH Month Jan. Day 10, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR: Months 53 Days 53 Hours 53 Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Anderson, Ind.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Clarence E. Merryman		14. MOTHER'S MAIDEN NAME Nellie Zion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Husband Address Item #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis - General 16d.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma - Bronchogenic DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1957 to Jan 10, 1958 , that I last saw the deceased alive on Jan 4, 1958 , and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1028 Conn Ave NW, Wash 6 D.C. DATE SIGNED Beveridge Miller			
ACTUAL SIGNATURE Beveridge Miller M.D.		PHYSICIAN'S NAME (Type) BEVERIDGE MILLER M.D. Wash 6 D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert a. Pumphrey		24. REC'D BY REGISTRAR JAN 13 '58	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 10 1958

RECEIVED

942 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Lutes Lane		d. STREET ADDRESS 5 Lutes Lane		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First EILEEN Middle C Last PIPER		4. DATE OF DEATH Month Jan. Day 15 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10 1911		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most working life or retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Cristopher Carey		14. MOTHER'S MAIDEN NAME Mc Manchon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no, or unknown) No (If yes, give war or dates of service) #####		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT George A. Piper, Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary of Lung DUE TO Thrombosed Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 8, 1957 to Jan 15, 1958 , that I last saw the deceased alive on Jan 15, 1958 , and that death occurred at 9:34 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Kenneth F. Laughlin M.D.		ADDRESS (Street, city or town, state) 934 Ellsworth Drive Silver Spring Md. DATE SIGNED 1-15-58			
PHYSICIAN'S NAME (Type) Kenneth F. Laughlin		22a. BURIAL CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Jan. 18 1958		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Silver Spring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE Jan 15 1958		24b. REGISTRAR'S SIGNATURE Paul J. ...	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. O'NEILL

JAN 20 1900

151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1101 DRYDEN STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) ANNA First (NMI) Middle PRIEDITE Last		4. DATE OF DEATH JANUARY 11 19 58 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13, 1869
9. AGE (in years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (retired)	11. BIRTHPLACE (State or foreign country) LATVIA
12. CITIZEN OF WHAT COUNTRY? LATVIA		13. FATHER'S NAME JANIS GOLDBERGS	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. REINHOLDS KARKLINS, 1101 DRYDEN ST., SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED JAN. 12, 1958	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 13, 1958	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Pumphrey		24a. REC'D BY REGISTRAR JAN 14 '58	
24b. REGISTRAR'S SIGNATURE Wm. E. Pumphrey		24c. REGISTRAR'S SIGNATURE Wm. E. Pumphrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1938

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00926

Reg. Dist. No.

944

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10204 Haywood Dr.</u>			d. STREET ADDRESS <u>10204 Haywood Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carrie Virginia Pyle</u>			4. DATE OF DEATH <u>Jan 15 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1868</u>		9. AGE (In years, last birthday) <u>89</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>M. Harris</u>			14. MOTHER'S MAIDEN NAME <u>Amelia Newton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Virginia E. Strobel - Same as Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan 15-1958</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Concord Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Pk Co Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - Riverdale, MD</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Decker</u>	
		DATE		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 17 1958

U. S.

JAN 17 1960

RECORDED

945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) b. STATE Tennessee c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sneadville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #1			
3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Ramsey				4. DATE OF DEATH Month January Day 22 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1924		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Ramsey				14. MOTHER'S MAIDEN NAME Donna Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW II (If yes, give year or dates of service)		16. SOCIAL SECURITY NO 411-36-5393		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 30, 1957 , to January 22, 1958 , that I last saw the deceased alive on January 22, 1958 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger Lester				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1/22/58	
PHYSICIAN'S NAME (Type) Roger Lester, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/25/58		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chung Chase Funeral Home				24a. REC'D BY REGISTRAR DATE JAN 24 '58		24b. REGISTRAR'S SIGNATURE Ree!	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

946

CERTIFICATE OF DEATH

00928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gaithersburg				c. LENGTH OF STAY IN 1b 10 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1 Gaithersburg, Md.				d. STREET ADDRESS / Rt. #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elijah First None Middle Redmon Last				4. DATE OF DEATH Jan. Month 27 Day 19 Year 58			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1882? 76? yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Redmon				14. MOTHER'S MAIDEN NAME Octavious Redmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret Burdette Address Rt. #1 Gaithersburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Heart Failure DUE TO Artery + Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart (c) Disease						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1956 , to Jan. 27, 1958 , that I last saw the deceased alive on Jan. 14, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Jack Schumacher M.D.				DATE SIGNED 1-29-58			
PHYSICIAN'S NAME (Type) Dr. Jack Schumacher				Medical Arts Bldg. Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58		22c. NAME OF CEMETERY OR CREMATORY Dickerson Methodist		22d. LOCATION (City, town, or county) (State) Dickerson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boyd Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR Feb 3 1958		24b. REGISTRAR'S SIGNATURE W. H. Smith	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

00929

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3131 MILITARY RD. N.W.</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward George Reinhard</u>				4. DATE OF DEATH Month Day Year <u>January 29 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 20, 1899</u> 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, or if retired) <u>Biologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH REINHARD</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SCHMIDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>459-52-4213</u>		17. INFORMANT <u>Wife</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>"</u> DUE TO <u>"</u> (c) <u>"</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 9, 1958</u> to <u>Jan 29, 1958</u> that I last saw the deceased alive on <u>Jan 29, 1958</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D. <u>5576 Nebraska Ave</u> ADDRESS (Street, city or town, state)				DATE SIGNED <u>1-30-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE-OF-HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>SILVER SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Gehlin</u> ADDRESS <u>3821-14th ST. N.W. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

948

CERTIFICATE OF DEATH

Reg. Dist. No.

00930

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANIT.</u>				d. STREET ADDRESS <u>11003 HIGHLAND DR.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>R.</u> Last <u>RICKETS</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>8</u> Year <u>1958</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 11, 1889</u>	9. AGE (in years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>RICHARD B. HAYDEN</u>				14. MOTHER'S MAIDEN NAME <u>ORA BRINKLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT Address <u>MRS MARY V FRAZIER (Above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 Cardiac decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8-9 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>1958</u> , that I last saw the deceased alive on <u>29 Dec</u> , 1957, and that death occurred at <u>9:24 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Auld</u> M.D.				DATE SIGNED <u>906 Walsville Rd 1/8/58</u>			
PHYSICIAN'S NAME (Type) <u>William D Auld</u>				ADDRESS (Street, city or town, state) <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENGWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Cattarull</u> ADDRESS <u>3603 14th ST NW</u>				24a. REC'D BY REGISTRAR <u>ONE 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) b. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fast Glenelg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morris Middle W. Last Ridgely		4. DATE OF DEATH Month January Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Ridgely		14. MOTHER'S MAIDEN NAME Ruth J. Ridgely Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. ?	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Arteriosclerotic heart disease with myocardial insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes mellitus (b) 5 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1955 , to Jan 12, 1958 , that I last saw the deceased alive on Jan. 11, 1958 , and that death occurred at 12:10am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-13-58			
ACTUAL SIGNATURE Charles S. Whitaker M.D.			
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D., Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-15-58	22c. NAME OF CEMETERY OR CREMATORY Mt. View	22d. LOCATION (City, town, or county) (State) Alpha, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR JAN 15 '58	
		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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950 CERTIFICATE OF DEATH

Reg. Dist. No. 00932

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 3000 Briggs Chaney Road	
3. NAME OF DECEASED (Type or print) First Sarah Middle Ellen Last Robey		4. DATE OF DEATH Month January Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/92 81
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Horace Harrison		14. MOTHER'S MAIDEN NAME Julia Athey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 3132 Briggs Chaney Rd.	
17. INFORMANT Mrs. William E. Lusby Silver Spring		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25/58 to 11/27/58 , 19 58 , that I last saw the deceased alive on 11/23/58 , 19 58 , and that death occurred at 3:05 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 1/23/58 ACTUAL SIGNATURE J. W. Bird M.D. PHYSICIAN'S NAME (Type) J. W. Bird, M. D. Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/27/58	
22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm E. Humphrey		24. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR JAN 27 1958	

MEDICAL CERTIFICATION

BUREAU V. S.

JAN 27 1950

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JAN 27 1950

951 CERTIFICATE OF DEATH

Reg. Dist. No. 00933

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germanstown,				c. LENGTH OF STAY IN 1b POOLESVILLE,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS POOLESVILLE,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LOURETTA Middle SPRING Last ROBINSON				4. DATE OF DEATH Month Jan. Day 1 Year 19 58			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1957		9. AGE (In years last birthday) yrs 4	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME George C. Robinson				14. MOTHER'S MAIDEN NAME Bertha E. Wims			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT George C. Robinson		Address Poolesville, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 492x DUE TO Pneumonia atypical Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 29 19 57 , to Jan 1 19 58 , that I last saw the deceased alive on Jan 1 19 58 , and that death occurred at 10:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Germanstown, Md. DATE SIGNED 12-58 ACTUAL SIGNATURE Dr. V.E. Martens M.D. md. PHYSICIAN'S NAME (Type) V.E. Martens							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/58		22c. NAME OF CEMETERY OR CREMATORY Poolesville,		22d. LOCATION (City, town, or county) (State) Poolesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 1958	
				24b. REGISTRAR'S SIGNATURE Robert L. Snodden			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. B.

952

CERTIFICATE OF DEATH

Reg. Dist. No. 9934

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		d. STREET ADDRESS 1214 MADISON ST NW	
3. NAME OF DECEASED (Type or print) First NELSON Middle E Last ROSS		4. DATE OF DEATH Month JANUARY Day 1 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 5, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY WESTERN UNION	
11. BIRTHPLACE (State or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NELS ROSS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-63-7603	
17. INFORMANT GENE ROSS 42 RICHMOND AVE W. F. 31		Address W. F. 31	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (Hardened Arteries) DUE TO Serious - age (±) 65 (c) Serious - age (±) 65			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1957 , to 1/6/58 , 19 58 , that I last saw the deceased alive on 1/6/58 , 19 58 , and that death occurred at 5:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, MD DATE SIGNED 1/6/58			
ACTUAL SIGNATURE Joseph E. Sowers M.D.		PHYSICIAN'S NAME (Type) Joseph E. Sowers	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF JAN. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) BUFFALO, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Sowers, Sowers, D.C.		24a. REC'D BY REGISTRAR DATE JAN 8 '58	24b. REGISTRAR'S SIGNATURE W. E. Sowers

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 4 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 8 1939

BUREAU V. S.

953

CERTIFICATE OF DEATH

Reg. Dist. No.

00935

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
c. LENGTH OF STAY IN 1b 15 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Mississippi Avenue				d. STREET ADDRESS 508 Mississippi Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BENSON Middle SEYMOUR Last ROWE				4. DATE OF DEATH Month Jan. Day 13 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/2/82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper (retired)		10b. KIND OF BUSINESS OR INDUSTRY Barber & Ross		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John K. Rowe				14. MOTHER'S MAIDEN NAME Ellen R. Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Virginia E. Rowe, 508 Mississippi Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4x0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic coronary disease DUE TO (c) Accelerated arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Chronic bronchial asthma INTERVAL BETWEEN ONSET AND DEATH 2 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1953 to Jan 13, 1958 that I last saw the deceased alive on Jan 10, 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1319 Seminary Rd. Silver Spring Md. DATE SIGNED 1-13-58 ACTUAL SIGNATURE John S. Rogers M.D. PHYSICIAN'S NAME (Type) JOHN S. ROGERS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/15/58		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				24a. REC'D BY REGISTRAR JAN 15 '58		24b. REGISTRAR'S SIGNATURE R. W. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JAN 17 1973

RECEIVED

954

CERTIFICATE OF DEATH

Reg. Dist. No.

00936

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300 Ambler Drive		d. STREET ADDRESS 4300 Ambler Drive	
3. NAME OF DECEASED (Type or print) WALTER W. RUDERICH		4. DATE OF DEATH Jan, 26, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1888
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR 2 Months 8 Days IF UNDER 24 HRS. 8 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-		10b. KIND OF BUSINESS OR INDUSTRY Red Star Yeast Co.	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry Ruderich		14. MOTHER'S MAIDEN NAME Frances Best	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 387-09-6980A	
17. INFORMANT Mary Ruderich-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerosis - Generalized DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 1 week yr? yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Jan 26, 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1957 to Jan 26, 1958 , that I last saw the deceased alive on Jan 26, 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Allen M.D.		DATE SIGNED 1/26/58	
PHYSICIAN'S NAME (Type) Samuel Allen - Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 1/27/58	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR Jan 28 '58	
24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

955 CERTIFICATE OF DEATH

Reg. Dist. No. 215

00937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>10 min</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>823 Barnaby Street, S.E.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl RUMPLIK</u>				4. DATE OF DEATH Month Day Year <u>January 9 19 58</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 January 1958</u>		9. AGE (In years last birthday) yrs. <u>10</u> IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Rudolph Hoover RUMPLIK</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte FITCH</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No - -</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) Rudolph H. RUMPLIK (Same As #2)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prolapse of the Umbilical Cord</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>10</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9 January 19 58</u> to <u>9 January 19 58</u> , that I last saw the deceased alive on <u>9 January 19 58</u> , and that death occurred at <u>3:45A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Kenneth W. Sell</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 1-10-58</u> PHYSICIAN'S NAME (Type) <u>Kenneth W. Sell, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>						24a. REC'D BY REGISTRAR <u>DATE JAN 13 58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1/11 4 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

956

CERTIFICATE OF DEATH

00938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
c. LENGTH OF STAY IN 1b <u>10 das</u>		d. STREET ADDRESS <u>Russell Rd. at Mt. Vernon Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7709 Meadow Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORINNA LESUEUR RUSSELL</u>		4. DATE OF DEATH Month Day Year <u>January 4, 19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alexander A. Lesueur</u>		14. MOTHER'S MAIDEN NAME <u>Trigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Alexander L. Russell, 7709 Meadow Lane</u>	
17. INFORMANT <u>Alexander L. Russell, 7709 Meadow Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture of right radius.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell in own home on level floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12/23/57</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Alexandria, Va.</u>	
21. I certify that I attended the deceased from <u>Nov 19 49</u> , to <u>JAN 4, 19 58</u> , that I last saw the deceased alive on <u>DEC 24, 12 58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1/4/58</u> STATE SIGNED			
ACTUAL SIGNATURE <u>Louis Ross</u>		M.D. <u>915 19th St., NW., Washington, DC</u>	
PHYSICIAN'S NAME (Type) <u>Louis Ross</u>		(Montgomery County Coroner notified & approved)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan 5-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sikeston</u>		22d. LOCATION (City, town, or county) (State) <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons, Wash. DC.</u>		ADDRESS <u>Wash. DC.</u>	
24a. REC'D BY REGISTRAR <u>W. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1958

RECEIVED

957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital 5721 Grosvenor Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eunice Tyree Ryan		4. DATE OF DEATH Month January Day 4 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1874
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Woodson A. Tyree		14. MOTHER'S MAIDEN NAME Mary J. Houston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records at Resmor Sanitarium & Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Enteric Sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from July 1, 1930 to Jan 4, 1958 , that I last saw the deceased alive on Dec 29, 1957 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE William T. Gill M.D. 1746-K Street N.W. Wash. D.C. DATE SIGNED 1/7/58 PHYSICIAN'S NAME (Type) WILLIAM T. GILL M.D. 22a. BURIAL CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/7/58 22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens 22d. LOCATION (City, town, or county) (State) Arlington, Virginia 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W. 24a. REC'D BY REGISTRAR Jan 8 58 24b. REGISTRAR'S SIGNATURE C. J. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

1938

RECEIVED

CERTIFICATE OF DEATH

00940

Reg. Dist. No.

958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Philomena Sattell</u>				4. DATE OF DEATH Month Day Year <u>Jan 24 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22, 1925</u>	9. AGE (In years last birthday) <u>32</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Martinus</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Elmer Sattell (H) 1601 Coral Sea Dr, Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>							<u>14 hours</u>
DUE TO <u>Cerebral</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Ruptured Aneurysm, Middle Cerebral Artery</u>							<u>14 hours</u>
DUE TO (c) <u>Congenital Berry Aneurysm</u>							<u>33 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>23 Jan., 1958</u> , to <u>24 Jan., 1958</u> , that I last saw the deceased alive on <u>24 Jan., 1958</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas C. Maganzini</u>				M.D. <u>809 Viers Mill Rd</u>			
PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>				<u>Rockville, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7N

RECEIVED

959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RESMOR SANITARIUM & Hospital</u>		d. STREET ADDRESS <u>2110 N. 16th ST</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY PAUL SAMPLE</u>		4. DATE OF DEATH <u>January 27 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Sept 1882</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk, U.S. Senate</u>	
11. BIRTHPLACE (State or foreign country) <u>Nightstown, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Andrew Sample</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Berk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles E. Danziger</u>		Address <u>2110-16th St. N. Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>January</u> , 1958, that I last saw the deceased alive on <u>January 27</u> , 1958, and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Curtin</u>		M.D. <u>900 17th ST N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. CURTIN</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence Samson</u>		24a. REC'D BY REGISTRAR <u>Jan 30 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Jan 30 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. A.

1911

RECEIVED

CERTIFICATE OF DEATH

00942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Warren</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smith's Grove</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>R 4</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>King</u> Last <u>Sanderson</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>America</u>	
13. FATHER'S NAME <u>Robert M. Sanderson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Milton Richardson</u>		Address <u>R 4 Smith's Grove, Ky.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>colony thrombotic infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>hypertensive heart disease</u> DUE TO (c) <u>tetramin congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1071</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>tetramin congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/8</u> , 19 <u>58</u> , to <u>1/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>58</u> , and that death occurred at <u>129</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John V. Dolan</u>		DATE SIGNED <u>31 Oct 58</u>	
PHYSICIAN'S NAME (Type) <u>John V. Dolan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cane City Cme.</u>	22d. LOCATION (City, town, or county) (State) <u>Cane City Ky.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 N. 22nd St. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>William J. Peoples</u>		DATE <u>JAN 28 58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEAU V. S.

1873

CERTIFICATE OF DEATH

00943

Reg. Dist. No. 215

961

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>District of Columbia</u> ^{4 CONNERY}	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>1109 5th St. S.E. Apt. 11</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>SCOTT</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 January 1958</u>
9. AGE (In years lost birthday) yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Ronald Melvin SCOTT</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Marie BRADLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Ronald M. Scott, (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal Abnormalities</u> DUE TO (c) <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 January, 19 58</u> , to <u>21 January, 19 58</u> , that I last saw the deceased alive on <u>21 January, 19 58</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Adam T. Thorp, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>		1-23-58	
PHYSICIAN'S NAME (Type) <u>Adam T. Thorp, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander Pope</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	
ADDRESS <u>Alexander Pope, 414 15th St. S.E. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1968

BUREAU V. S.

Reg. Dist. No. 944

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. If its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		e. STREET ADDRESS 6415 Lybrook Dr.	
3. NAME OF DECEASED (Type or print) Stewart Kendall Scott		4. DATE OF DEATH Month Day Year Jan. 11, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1957
9. AGE (in years last birthday) 108 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 2 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert M. Scott		14. MOTHER'S MAIDEN NAME Marion Wheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Marion Scott (mother) Same as Ith 2	
17. INFORMANT Marion Scott (mother) Same as Ith 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial pneumonia X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED Jan. 11, 1958	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/57	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D C	
23. FUNERAL DIRECTOR'S SIGNATURE Joe Lawler Sons Inc.		24a. REC'D BY REGISTRAR DATE JAN 14 '58	
ADDRESS 1756 Penna Ave NW Washington		24b. REGISTRAR'S SIGNATURE W. H. Beach	

RECEIVED

14 NOV 1958

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00945

963

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myrtle Scrivens		4. DATE OF DEATH Month Jan Day 6 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1875
9. AGE (In years last birthday) yrs 82		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Poole		14. MOTHER'S MAIDEN NAME Mary E. Howe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (if yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Emilie Scrivens		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Apoplexy DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 10 Year 1958 Hour a. m. 10 p. m. 10		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify (that I attended the deceased from Nov 10, 1957 to Jan 6, 1958 , that I last saw the deceased alive on Jan 5, 1958 , and that death occurred at 3:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Georgetown Rd Bethesda 14 Md DATE SIGNED Jan 7 '58			
ACTUAL SIGNATURE Leo I. Donovan M.D.		PHYSICIAN'S NAME (Type) LEO I. DONOVAN M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/7/58	22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park Cemetery	22d. LOCATION (City, town, or county) (State) Falls Church, Va.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR Jan 7 '58	
24b. REGISTRAR'S SIGNATURE Overseer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00946

964

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b X KENSINGTON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11,223 EAST AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON d. STREET ADDRESS 11,223 EAST AVENUE	
3. NAME OF DECEASED (Type or print) First MARY Middle EMADEAN Last SHEPPERD		4. DATE OF DEATH Month JAN. Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PORTLAND, OREGON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR RAY NELSON		14. MOTHER'S MAIDEN NAME HELEN JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 533-12-1074	
17. INFORMANT Mr. Irving J. Shepperd, 11,223 East Ave. Kensington, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema due to acute hemorrhagic sudden DUE TO Conditions, if any, which gave rise to immediate cause (b) pancreatitis (c) pancreatitis DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) 1/27/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		24a. REC'D BY REGISTRAR JAN 27 '58	
		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

BURNHAM K.S.

JAN 27 1968

JOHN A. BURNHAM

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 144847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Hawaii</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Puunene</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7057 Carroll Ave</u>				d. STREET ADDRESS <u>P.O. Box 462</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred Ichiro Shimomura</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>yellow</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-1917</u>	
9. AGE (in years last birthday) <u>40</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Hawaii</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Kisabura Shimomura</u>				14. MOTHER'S MAIDEN NAME <u>Eli Shimomura</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW II 568-40-8828</u>		17. INFORMANT <u>Eli Shimomura (wife)</u> Address <u>Same as item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-26-58</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 31 1958

BUREAU OF

965

CERTIFICATE OF DEATH

00948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Mont. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 6631 Western Avenue N W			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JENNIE Middle GROVES Last SHIPMAN				4. DATE OF DEATH Month 1-9-1958 Day 19 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 17, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Indian Head, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Groves				14. MOTHER'S MAIDEN NAME Mary Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-05-0012B			
17. INFORMANT John B. Shipman				Address 6631 Western Ave NW Washington, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO 100.0							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general DUE TO yr							
(c) Fracture of 82+ DUE TO yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/12/58 , 19___, to 1/19/58 , 19___, that I last saw the deceased alive on 1/15/58 , 19___, and that death occurred at 7:00 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Kensington, Md. DATE SIGNED 1/19/58							
ACTUAL SIGNATURE Sam Allen M.D. 1/19/58							
PRINTED NAME (Type) SAM ALLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/58		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem		22d. LOCATION (City, town, or county) (State) Washington, D C	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulina Sasso ADDRESS 1756 Pennsylvania Ave				24a. REC'D BY REGISTRAR JAN 14 '58		24b. REGISTRAR'S SIGNATURE Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1958

RECEIVED

836

CERTIFICATE OF DEATH

00949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>820 Longfellow St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>—</u> Last <u>Sisgold</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>							
13. FATHER'S NAME <u>Benny Sisgold</u>				14. MOTHER'S MAIDEN NAME <u>Sharon (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction (acute)</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (artery)</u> DUE TO <u>—</u> (c) <u>Terminal cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>1 yr</u> <u>2 wks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>May 7, 1958</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 7, 1958</u> to <u>Jan 18, 1958</u> , that I last saw the deceased alive on <u>Jan 18, 1958</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>934 Ellsworth St. Silver Spring, Md.</u>				DATE SIGNED <u>1-18-58</u>			
ACTUAL SIGNATURE <u>Kenneth Laughlin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>KENNETH LAUGHLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. K. Montgomery & Son</u> ADDRESS <u>3501-14 St. N.W.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. S.

JAN 21 1939

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

837

CERTIFICATE OF DEATH

00950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wheaton Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sta. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. George Henry Skinner</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-05</u>	
9. AGE (In years last birthday) yrs <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>Ernest L. Skinner</u>				14. MOTHER'S MAIDEN NAME <u>Della Mae ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-05-2749</u>		17. INFORMANT <u>Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longest Cardiac Failure Terminating in Atrial Fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Myocardial Infarction Posterior Septal</u> DUE TO (c) <u>Thrombosis Rt. Coronary artery</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Infarction Left due to Pulmonary Embolus</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1955, to <u>Jan. 26</u> , 1958, that I last saw the deceased alive on <u>Jan. 26</u> , 1958, and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 Georgia Ave. Silver Spring Md.</u> <u>JAN. 26, 1958</u>							
ACTUAL SIGNATURE		SIGNATURE (Type) <u>JAMES A. ROBERTS M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. B. Humphrey</u>			

BUREAU V. S.

1958

RECEIVED

966

CERTIFICATE OF DEATH

Reg. Dist. No.

00951

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2626 Colston Drive		d. STREET ADDRESS 2626 Colston Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM (nmi) SLINEY		4. DATE OF DEATH January 1, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/77
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 1 Days 18	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Patrick Sliney		14. MOTHER'S MAIDEN NAME Margaret Murry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Howard Bernstein-Item# 2	
17. INFORMANT Howard Bernstein-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4 a.u.o DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, General DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 18 yrs(?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 1956 to JAN. 1, 1958 , that I last saw the deceased alive on DEC 31, 1957 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Leo M. Curtis M.D. 8218 Wisconsin Ave Bethesda Md.		1/1/58	
PHYSICIAN'S NAME (Type) Leo M. Curtis			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Bur.-Transit	1/1/57	St. Josephs	Columbus, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 6 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE U. Meduch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE



967

CERTIFICATE OF DEATH

00952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7006 Exeter Road		d. STREET ADDRESS 7006 Exeter Road	
3. NAME OF DECEASED (Type or print) MRS E. A. G. Smith		4. DATE OF DEATH JAN 31 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/85
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR 9 Months 19 Days 19 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Jefferson Adams		14. MOTHER'S MAIDEN NAME Mary Jane Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Russell A. Smith-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease II DUE TO (c) 15 yrs		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1957 to 31 June 1958 , that I last saw the deceased alive on 29 June 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert Markov Jr M.D.		ADDRESS (Street, city or town, state) 5024 Bethesda Ave	
PHYSICIAN'S NAME (Type) HERBERT MARKOV JR		DATE SIGNED 31 June 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 1/31/58	
22c. NAME OF CEMETERY OR CREMATORY Sunset		22d. LOCATION (City, town, or county) (State) Christiansburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR 1205	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1971

838

CERTIFICATE OF DEATH

Reg. Dist. No.

00953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurens Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>9109 Colesville Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>John Douglas Smith</u>				4. DATE OF DEATH <u>1-24-58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-76</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR <u>81</u> Months		IF UNDER 24 HRS. <u>81</u> Days		IF UNDER 24 HRS. <u>81</u> Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher (RETIRED)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>America</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Alexander D. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Feeney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-26-017A</u>			
17. INFORMANT <u>Hospital Records</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis & Intestinal Obstruction and gangrene small bowel</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
DUE TO (b) <u>Postoperative strangulated hernia inguinal</u>				DUE TO (c) <u>7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>John</u>				20f. (City or town) <u>Jan.</u> (County) <u>1958</u> (State) <u>1958</u>			
21. I certify that I attended the deceased from <u>Jan 23</u> 19 <u>58</u> , to <u>Jan 24</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 23</u> 19 <u>58</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) <u>217 University Blvd E</u> DATE SIGNED <u>1-24-58</u>			
ACTUAL SIGNATURE <u>Bernard G. Fitzgerald</u> M.D.				PHYSICIAN'S NAME (Type) <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-44th. NW Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Adrian Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1 1938

RECEIVED

968

CERTIFICATE OF DEATH

Reg. Dist. No.

00954

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincoln Ave., Rockville.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincoln Ave., Rockville.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Lincoln Ave., Rockville.</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence</u> First <u>Smith</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219056574</u>	
17. INFORMANT <u>Grand-daughter</u>		Address <u>Lincoln Ave., Rockville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric Carcinoma, inoperable</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1957</u> to <u>Jan. 21 1958</u> , that I last saw the deceased alive on <u>Jan. 20 1958</u> , and that death occurred at <u>4:55 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson</u>		DATE SIGNED <u>MD RDI, Gaithersburg, Md. 1-22-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View.</u>	22d. LOCATION (City, town, or county) (State) <u>Quince Orchard, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quince Orchard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

RECEIVED

969

CERTIFICATE OF DEATH

00955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			
d. STREET ADDRESS 3217 Connecticut Avenue, N. W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle (none) Last South				4. DATE OF DEATH Month January Day 20 , Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1881	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles S. Turnbull			
14. MOTHER'S MAIDEN NAME Elizabeth Claxton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Aortic embolism							
DUE TO (b) Myocardial Infarction							
DUE TO (c) Atherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs or more							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 19, 1957 , to January 20, 1958 , that I last saw the deceased alive on January 20, 1958 , and that death occurred at 2:51 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/21/58							
ACTUAL SIGNATURE N. Raphael Shulman M.D. National Institutes of Health							
PHYSICIAN'S NAME (Type) N. Raphael Shulman, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 1/24/58							
22c. NAME OF CEMETERY OR CREMATORY Arlington National							
22d. LOCATION (City, town, or county) (State) Ft. Myer Va.							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 1400 Chapin St NW							
24a. REC'D BY REGISTRAR WASH, DC DATE JAN 23 1958							
24b. REGISTRAR'S SIGNATURE Chambers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. M.

JAN 21 1958

RECEIVED

970

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00956

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANN</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c LENGTH OF STAY IN 1b <u>9 Hr. 45 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>		e STREET ADDRESS <u>1980 Fairfax Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Deborah Lynn SOWELL</u>		4. DATE OF DEATH Month Day Year <u>January 21 19 58</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>19 January 1958</u>
9. AGE (In years last birthday) yrs <u>2</u>		IF UNDER 1 YEAR Months Days <u>2</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard David SOWELL, Jr.</u>		14 MOTHER'S MAIDEN NAME <u>Lois Grimm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Richard D. Sowell (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fetal Atelelectasis</u> DUE TO (c) <u>Immaturity</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 January, 19 58</u> to <u>21 January, 19 58</u> , that I last saw the deceased alive on <u>21 January, 19 58</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Adam G. Thorp, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 1-21-58</u> PHYSICIAN'S NAME (Type) <u>Adam G. Thorp, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Naval Academy Cemetery</u>	22d LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Taylor Funeral Home, Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>2 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

2063263xv1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 23 1968

BUREAU V. B.

971

CERTIFICATE OF DEATH

Reg. Dist. No.

00957

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1225 Woodside Parkway		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy	
		d. STREET ADDRESS Park Avenue	
3. NAME OF DECEASED (Type or print) Mollie Buxton Spurrier		4. DATE OF DEATH Month January Day 26 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Plane #4 Mt. Airy, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Thomas Buxton		14. MOTHER'S MAIDEN NAME Sarah Brengle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Blanche S. Marsh, 1225 Woodside Pkwy., SS., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic myocarditis with mild failure 179.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Generalized metastatic carcinomatosis origin undetermined (c) Residual left hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 5 weeks Est. 17 yrs. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 DEC. , 19 57 , to 26 JAN. , 19 58 , that I last saw the deceased alive on 26 JAN. , 19 58 , and that death occurred at 4:24 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Marshall Cuvillier, Jr.		ADDRESS (Street, city or town, state) 1407 Woodside Parkway, Silver Spring, Maryland	
DATE SIGNED 1/26/58			
PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Airy, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence E. Rumphey		24a. REC'D BY REGISTRAR DATE JAN 28 '58	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 11 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

839

CERTIFICATE OF DEATH

00958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella Hazeelett Steinhauer</u>				4. DATE OF DEATH Month Day Year <u>Jan. 26 1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-88</u>	9. AGE (In years last birthday) yrs. <u>69 1/2</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>3 11</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edwin Hazel</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bolan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Medical Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Hypertensive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic atherosclerotic cardiovascular disease</u> DUE TO (c) <u>disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>about 8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>DECEMBER 1945</u> , to <u>JAN 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 26</u> , 19 <u>58</u> , and that death occurred at <u>10:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7733 ARASKA AVE N.W. VAN 26 45</u>							
ACTUAL SIGNATURE <u>Robert L. Krichmar</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>				<u>WASHINGTON 12 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>1/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKean Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>McKean County, Pennsylv.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. M. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

JAN 10 1953

RECEIVED

00959

CERTIFICATE OF DEATH

Reg. Dist. No.

972

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
f. STREET ADDRESS 4413 Everett St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zella ^{First} Gaines ^{Middle} Summers ^{Last}		4. DATE OF DEATH Month Jan Day 24 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 6 Days 15 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Oakdale, Tenn.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eli McGill		14. MOTHER'S MAIDEN NAME Lou Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Malinda Summers - Daughter	
17. INFORMANT Malinda Summers - Daughter		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS GENERALIZED DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4601 16th St NW, Wash DC		20f. (City or town) (County) (State) Wash DC	
21. I certify that I attended the deceased from 1/2/3/ 19 55 to JAN 14 19 58 , that I last saw the deceased alive on JAN 13 19 58 , and that death occurred at 2:02 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4601 16th St NW, Wash DC DATE SIGNED 1/14/58			
ACTUAL SIGNATURE Richard H. Spire M.D.			
PHYSICIAN'S NAME (Type) RICHARD H. SPIRE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/58	
22c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		22d. LOCATION (City, town, or county) (State) Oakdale, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR 1/16/58	
ADDRESS 300 4th NE, Wash. DC		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00960

973

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle E Last Talbot		4. DATE OF DEATH Month January Day 26 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 74
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rubin Looms		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Marion L. Peritz		Address daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Auricular Fibrillation DUE TO (c) Hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 minutes year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 19 55 , to Jan 26 19 58 , that I last saw the deceased alive on Jan. 21 19 58 , and that death occurred at 4 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome J. Krick		ADDRESS (Street, city or town, state) 2800 Quebec Street, N.W.	
PHYSICIAN'S NAME (Type) Jerome J. Krick		DATE SIGNED Jan 21 1958	
22a. REMOVAL (Specify)		22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORY Batavia Cemetery
22d. LOCATION (City, town, or county)		(State) Batavia, New York	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		24. REGISTRAR'S SIGNATURE Wash. D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JAN 23 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

974

CERTIFICATE OF DEATH

Reg. Dist. No.

00961

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville, Rural		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOE EARLY TAYLOR		4. DATE OF DEATH Month Day Year JANUARY 22 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 12, 1957
9. AGE (In years last birthday) yrs. 2 10 Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph E. Tayler		14. MOTHER'S MAIDEN NAME Catherine Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Tayler, Germantown, R.F.D. 1—Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BRONCHIAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4012 None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 12, 1957 , to 19 Jan. 1958 , that I last saw the deceased alive on 19 Jan. 1958 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Danversville DATE SIGNED P.O. Boyd, Md			
ACTUAL SIGNATURE John C. Fawcett M.D.		PHYSICIAN'S NAME (Type) JOHN C. FAWCETT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58	
22c. NAME OF CEMETERY OR CREMATORY Montgomery		22d. LOCATION (City, town, or county) (State) Danversville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Wilson ADDRESS Danversville, Md		24. REC'D BY REGISTRAR Alfred 25. REGISTRAR'S SIGNATURE Alfred	

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CERTIFICATE OF DEATH

00962

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencove Springs</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda Md.</u>		d. STREET ADDRESS <u>114 "A" Street Orion Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Suella</u> Middle <u>(n)</u> Last <u>THONET</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 February 1957</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Darrell Owen THONET</u>		14. MOTHER'S MAIDEN NAME <u>Marise Elaine KELLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>(Father) THONET Darrell Owen</u>		Address <u>(Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>14 January, 1958</u> , to <u>27 January, 1958</u> , that I last saw the deceased alive on <u>27 January, 1958</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth W. Sell</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda Md.</u> DATE SIGNED <u>1-27-58</u>	
PHYSICIAN'S NAME (Type) <u>Kenneth W. SELL, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Gainsville Florida</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		ADDRESS <u>7557 Wisconsin Ave. Bethesda Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>no</u> STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Sally L. Toole</u>		4. DATE OF DEATH <u>Jan 31 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-85</u>
9. AGE (In yrs. & last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Berny Robey</u>		14. MOTHER'S MAIDEN NAME <u>Marian Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Hazel Kennedy</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st 2nd & 3rd degree burns involving</u>		DUE TO	
(c) <u>90% body, head & extremities</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chest pain caught while burning trash</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year <u>1/31 1958</u>	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Burtonsville</u> (County) <u>Monty</u> (State) <u>md</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-31-58</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial Feb 3, 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) <u>Burtonsville</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Caldwell</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>	
ADDRESS <u>W. H. Caldwell</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Caldwell</u>	

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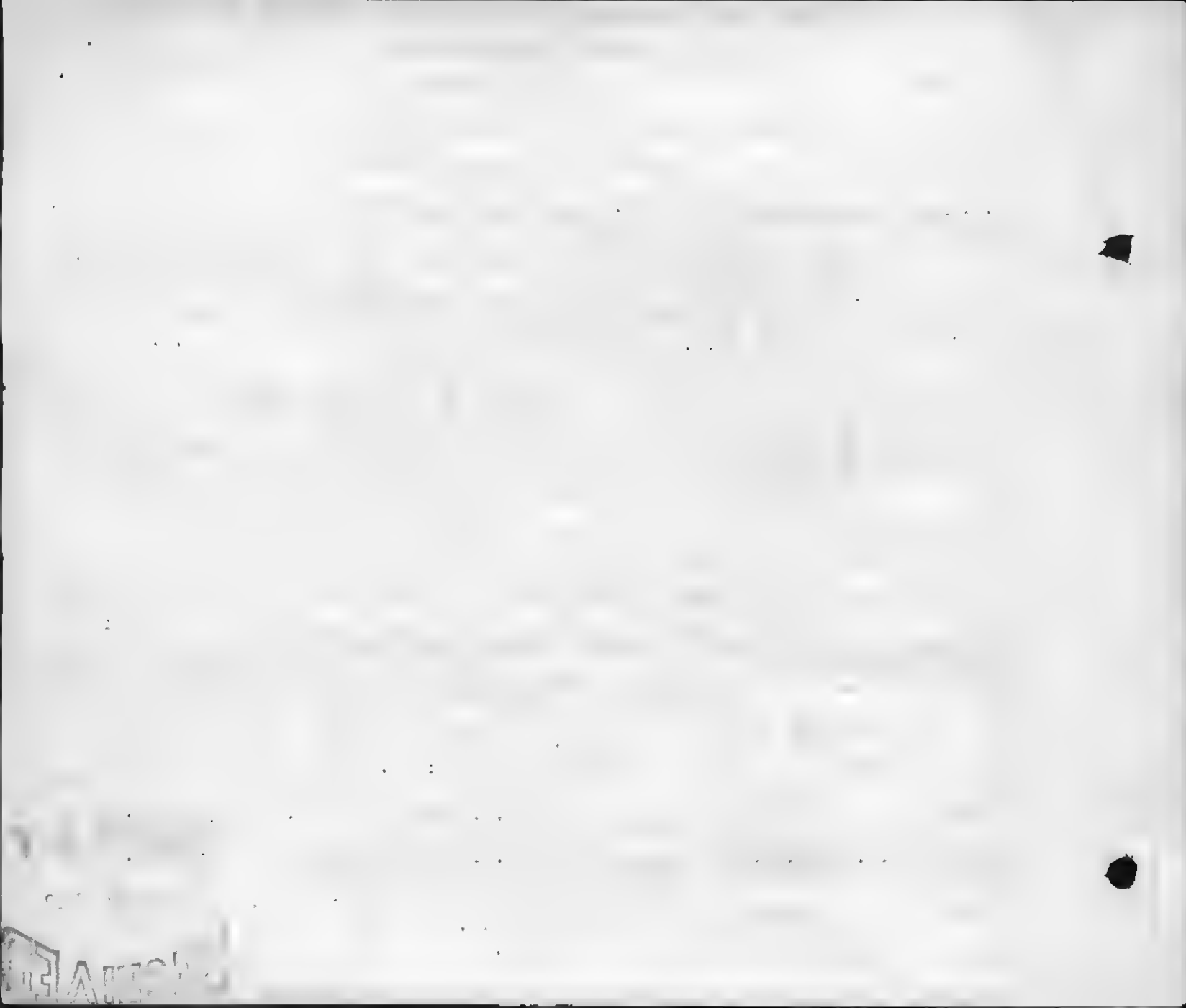
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>110 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkes-Barre</u>				d. STREET ADDRESS <u>754 Lehigh Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>John</u> Last <u>TUNILA</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 September 1935</u>		9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Marine Corps</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John TUNILA</u>				14. MOTHER'S MAIDEN NAME <u>Viola (Last Name Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1-28-53 to 1-4-58</u>		16. SOCIAL SECURITY NO. <u>188 28 4132</u>		17. INFORMANT <u>Official Navy Records</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Lymphatic Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> (County) (State)	
21. I certify that I attended the deceased from <u>19 Sept.</u> , 19 <u>57</u> , to <u>4 January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 January</u> , 19 <u>58</u> , and that death occurred at <u>6:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>1-6-58</u>							
ACTUAL SIGNATURE <u>T.S. Dunn, Jr.</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>T.S. DUNN, JR., LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bear Creek, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Funeral Home, 1400 Chapin Street, N.W.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



978

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 d. STREET ADDRESS 5513 Parkland Court, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Mylan Ugrinic		4. DATE OF DEATH Month Day Year January 20, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1918
9. AGE (In years last birthday) 39		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist		10b. KIND OF BUSINESS OR INDUSTRY Geology (Government)	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Ugrinic		14. MOTHER'S MAIDEN NAME Mary Capetonovich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 284-03-9095	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain Tumor L. Frontal lobe (Glioma) DUE TO (c) 6-7 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 13, 1958 , to January 20, 1958 , that I last saw the deceased alive on January 20, 1958 , and that death occurred at 9:16 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/21/58 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Robert E. Edgar	M. D. The Clinical Center		
PHYSICIAN'S NAME (Type) Robert E. Edgar, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-1958	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myer, Va
23. FUNERAL DIRECTOR'S SIGNATURE Richard Mattingly Ward, D.C.		24a. REC'D BY REGISTRAR DATE JAN 23 '58	24b. REGISTRAR'S SIGNATURE Outmail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1938

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00966

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6623 Kammork Road		e. STREET ADDRESS 6623 Kammork Road	
3. NAME OF DECEASED (Type or print) KATHARINE KATHARINE A UMSTOT		4. DATE OF DEATH Month Jan Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1885
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR 2 mos 27 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Benno Knoll		14. MOTHER'S MAIDEN NAME Mary Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or not unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO ---	
17. INFORMANT Mrs Wm. N. Ruby-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4 a.u. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschatt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschatt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-31-58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/58	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00967

980

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital			
d. STREET ADDRESS 9302 Jesup Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Felix Francis Vaun				4. DATE OF DEATH Month Day Year January 14 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1916	9. AGE (In years last birthday) 41 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY R.E. Darling Co.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Vaitekunas			14. MOTHER'S MAIDEN NAME Amelia ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO 377-40-8968		17. INFORMANT Wife Rosetta S. Vaun		Address 9302 Jesup La. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Acute coronary heart failure DUE TO (c) 6 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal - gastric junction - pleural fistula						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20d. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 5, 1957 to Jan 14, 1958 , that I last saw the deceased alive on 1-14 , 19 58 , and that death occurred at 10:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave Bethesda 14, Md. DATE SIGNED							
ACTUAL SIGNATURE Robert G. Brewer M.D.							
PHYSICIAN'S NAME (Type) Robert G. Brewer Bethesda 14, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Council			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD

1917

1917

CERTIFICATE OF DEATH

00968

Reg. Dist. No.

847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 E. Jefferson Street</u>				d. STREET ADDRESS <u>101 E. Jefferson Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>W</u> Last <u>VINSON</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 13, 1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Druggist-owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>John T. Vinson</u>			
14. MOTHER'S MAIDEN NAME <u>Rachael Prout</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Judge T. Anderson-W.</u> Address <u>Montg. Ave. Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent coronary thrombosis</u> DUE TO (b) <u>Severe atherosclerosis</u> DUE TO (c) <u>2 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>15</u> Year <u>1958</u> Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Rockville</u>				20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan 15, 1958</u> to <u>Jan 16, 1958</u> that I last saw the deceased alive on <u>Jan 15, 1958</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. A. Linthicum</u> M.D.				DATE SIGNED <u>1/16/58</u>			
PHYSICIAN'S NAME (Type) <u>Wm. A. Linthicum</u>				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washinton, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1910

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

981

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cethesda,</u>				c. LENGTH OF STAY IN 1b <u>10 hrs. 5 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottare City</u> <u>16x2</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bernard</u> Last <u>Wagoner</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9, 1876</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>58</u> Min.		IF UNDER 24 HRS. Months <u>8</u> Days <u>19</u> Hours <u>58</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Virginia paper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shirton, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Shirton, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Thomas Wagoner</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Poole</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>John D. Wagoner, Jr.</u> Address <u>7020 Annapolis Drive, Cethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4x20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Carcinoma Stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>7</u> Year <u>1958</u> Hour <u>10:50</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington Clinic</u>	
20f. (City or town) <u>Washington D.C.</u>				20g. (County) <u>Washington</u>		20h. (State) <u>D.C.</u>	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>Jan 1958</u> , that I last saw the deceased alive on <u>Jan 7, 1958</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert S. Jayler</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Washington D.C.</u>				DATE SIGNED <u>1/10/58</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				24a. RECEIVED BY REGISTRAR <u>2901 14th St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Washington, D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRITISH V. S.

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00970

982

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sewell's Maternity Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Vivian First Middle Last		4. DATE OF DEATH January 16 19 58 Month Day Year	
5. SEX female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 58 9. AGE (In years last birthday) yrs. 0 0 1 0 Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Premature		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTH PLACE (State or foreign country) Sewell's Maternity Hosp.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Walker		14. MOTHER'S MAIDEN NAME Vivian S. Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atalectasis Failure of respiration 7615 DUE TO Premature accidental ruptured Membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 7:30AM Jan. 15	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 16 1958 , to Jan. 16 1958 , that I last saw the deceased alive on Jan. 16 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Silver Spring Md	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE SIGNED 1/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/18/58	22c. NAME OF CEMETERY OR CREMATORY Good Hope,	22d. LOCATION (City, town, or county) (State) Colesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sorden		24a. REC'D BY REGISTRAR JAN 20 1958 DATE	24b. REGISTRAR'S SIGNATURE W. Sewell

JOHN V. S.

1911

1911

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00971

983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> Henry Canfield Walker MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Poolesville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Canfield Walker</u>		4. DATE OF DEATH Month Day Year <u>Jan 21, 1958</u> <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Walker</u>		14. MOTHER'S MAIDEN NAME <u>Julia E. Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Emma V. Adams</u>		Address <u>3387 Milwaukee Street Pittsburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Jan. 24, 1958</u>	
22a. BURIAL CREMATION, 22b. DATE THEREOF Burial (Specify) <u>1/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elijah,</u>	
22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00972

984

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Joseph</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>stone mason</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Walker</u>				14. MOTHER'S MAIDEN NAME <u>Lula A. Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Linda E. Allnutt, Washington Grove, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u> DUE TO <u>Fracture of left hip.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>12/1/57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on street</u>					
20c. TIME OF INJURY Month, Day, Year <u>Jan. 9, 1958</u> Hour <u>4:15 A.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Gaithersburg</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence (Meth.)</u>		22d. LOCATION (City, town, or county) (State) <u>Howard, County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u>		ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>R. Council</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

RECEIVED
JAN 9 1958
BUREAU V. S.

985 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 16</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4812 Western Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Russell</u> <u>Warner</u>		4. DATE OF DEATH <u>Jan</u> <u>7</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1898</u>
9. AGE <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Warner</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda Gehring</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Wife</u>		18. ADDRESS <u>Mrs Leona Warner</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>			
DUE TO <u>154X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
(b) <u>Circulatory Failure</u>			
(c) <u>Post-op. Ca of Rectum</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 21</u> , 1957 to <u>Dec 25</u> , 1957 that I last saw the deceased alive on <u>Dec 25</u> , 1957, and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John. M. Murphy</u>		DATE SIGNED <u>1801 Eye St. N. W. Wash. D.C. 1/7/58</u>	
PHYSICIAN'S NAME (Type) <u>John Murphy, M.D.</u>		ADDRESS <u>1801 Eye St. N. W. Wash. D.C.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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840

Item 2

CERTIFICATE OF DEATH

00974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRIPOLI, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Curtis Nursing Home</u>		d. STREET ADDRESS <u>3304 Parrett Road</u>	
3. NAME OF DECEASED (Type or print) <u>Esther</u> First Middle Last <u>Webster</u>		4. DATE OF DEATH <u>Jan 5 1958</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Webster</u>		14. MOTHER'S MAIDEN NAME <u>Esther F. Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George Dancy</u> Address <u>9 Smith Ave, Caldwell, N.J.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:20.0</u> DUE TO <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>			
(c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/18 1957</u> to <u>1/5 1958</u> , that I last saw the deceased alive on <u>1/3 1958</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8805 CONN. AVE</u>		DATE SIGNED <u>1/5/58</u>	
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		<u>CHEVY CHASE 15 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>JAN 6 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	22d. LOCATION (City, town or county) (State) <u>PRINCE GEORGE CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. Pumphrey</u> ADDRESS <u>8454 AVE</u>		24a. REC'D BY REGISTRAR <u>JAN 8 '58</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1958

RECEIVED

841

CERTIFICATE OF DEATH

00975

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>Jan. 3, 1958</u> <u>8:00 P.M.</u>				d. STREET ADDRESS <u>10132 Greenock Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>WEISS, MYRTIE LEE WEISS</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>4</u> Year <u>1958</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/97</u> 3-24-1907	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Distilled Spirits Est</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>George Harris</u>				14. MOTHER'S MAIDEN NAME <u>Cora Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>577-30-5146</u>		17. INFORMANT <u>Husband</u> Address <u>10132 Greenock Rd., S. Spring, Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Hypertension - (2) Cerebral Ischemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1952</u> to <u>4 Jan</u> , 1958, that I last saw the deceased alive on <u>4 Jan</u> , 1958, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Huff</u> M.D.				ADDRESS (Street, city or town, state) <u>9006 Glenville Rd</u> DATE SIGNED <u>14 Jan 58</u>			
PHYSICIAN'S NAME (Type) <u>William D. Huff, M.D.</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		22d. LOCATION (City, town, of county) <u>Suitland, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>C. C. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
1953

CERTIFICATE OF DEATH

Reg. Dist. No.

00976

848

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Wade Avenue		d. STREET ADDRESS 700 Wade Avenue	
3. NAME OF DECEASED (Type or print) First MATTIE Middle FRANCES Last WHIDBY		4. DATE OF DEATH Month JAN. Day 7 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 6 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Mencer		14. MOTHER'S MAIDEN NAME Frances Hargrave	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Sarah Ann Everhart-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 4-5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 4, 1955 , to 7 JAN 1958 , that I last saw the deceased alive on 3 JAN 1958 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. G. Hall		DATE SIGNED 1-7-58	
PHYSICIAN'S NAME (Type) W. G. Hall		ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Transit		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY Lasting Hope		22d. LOCATION (City, town, or county) (State) Columbia, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		40. REC'D BY REGISTRAR DATE JAN 9 '58	
41. REGISTRAR'S SIGNATURE Reid			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4- may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON V. E.

1891

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00977

Item 14-225 1-31-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>53 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Traveller Road</u>		d. STREET ADDRESS <u>Traveller Road</u>	
3. NAME OF DECEASED (Type or print) <u>Hattie Leora White</u>		4. DATE OF DEATH <u>Jan 11 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1867</u>
9. AGE (In years last birthday) <u>90 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>	
13. FATHER'S NAME <u>Stephen S. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Leora Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John White</u>	
17. INFORMANT <u>John White</u>		Address <u>Dune # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u>			
(c) <u>sloting the underlying cause lost.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Buschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BUSCHERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Mont., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 14 58</u>		24b. REGISTRAR'S SIGNATURE	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1958

BUREAU V. S.

Items 20&21 Film 986

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Williams		d. STREET ADDRESS 116 Cario Street	
4. DATE OF DEATH Month January Day 10 Year 19 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Williams		14. MOTHER'S MAIDEN NAME Lilly MacDarby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Hospital records - Self			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 1st, 2d & 3d degree burns involving about 3/4 of body, head & Extremities (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Red A house after probably cigarette		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11:42 a.m. 1/9 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Rockville (County) Montg. (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James J. Brown		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/58	22c. NAME OF CEMETERY OR CREMATORY County Home,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR JAN 14 1958		24b. REGISTRAR'S SIGNATURE W. J. Brown	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEAU V. E.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

98 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00979

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 25 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Good Hope Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS Good Hope Rd.	
3. NAME OF DECEASED (Type or print) Randolph		4. DATE OF DEATH Jan. 18, 1958	
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1882
9. AGE (in years, months, days) 75 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Wilson		14. MOTHER'S MAIDEN NAME Emma Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Garry Wilson		Address 1252 Owen Pl. N. E. Apt. 1 Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Valvular Heart Disease (c) 421.4 DUE TO stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED Jan. 20, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58	
22c. NAME OF CEMETERY OR CREMATORY Round Oak.,		22d. LOCATION (City, town, or county) (State) Spencerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swonder		ADDRESS Rookville, Md.	
24a. REC'D BY REGISTRAR JAN 27 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988

CERTIFICATE OF DEATH

00980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights	
f. STREET ADDRESS 139 Choctaw Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kathy Middle Sue Last Wissman		4. DATE OF DEATH Month January Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1957
9. AGE (In years last birthday) 2 yrs		IF UNDER 1 YEAR Months 21 Days 21 Hours 4 Min	IF UNDER 24 HRS Hours 4 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Wissman Jr.		14. MOTHER'S MAIDEN NAME Gwendolyn Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO None	
17. INFORMANT The Clinical Center, Bethesda 14, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Duodenal ulcer DUE TO (c) Congenital Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown 5 weeks 4 11 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1957 , to January 16, 1958 , that I last saw the deceased alive on January 16, 1958 , and that death occurred at 4:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/16/58 ACTUAL SIGNATURE Robert T. L. Long M.D. PHYSICIAN'S NAME (Type) Robert T. L. Long, M.D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 18/58	
22c. NAME OF CEMETERY OR CREMATORY ST. BARNABAS CEM.		22d. LOCATION (City, town, or county) (State) OXON HILL, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
ADDRESS Wash. D.C.		24b. REGISTRAR'S SIGNATURE Alfred Smith	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

842

CERTIFICATE OF DEATH

00981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>3145- 16th St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Robert</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-73</u>
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Rural Mail Carrier-U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>u.s.a</u>	
13. FATHER'S NAME <u>James Wood</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Daughter - Mrs Gladys Gray - 106-64th Pl. Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 16, 1958</u> , to <u>January 20, 1958</u> , that I last saw the deceased alive on <u>January 20, 1958</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>M.D. 1019 University Boulevard, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		DATE SIGNED <u>1/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mitchellville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Little Bros. Marboro, Md.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>John A. Leach</u>			

STAY AHEAD

1990

VS. AISME
\$M 2.57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7306 Holly Ave</u>		d. STREET ADDRESS <u>7306 Holly Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Calvin William Wright</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Clarence H. Wright</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Harding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Clarence Wright - R-2 Silver Spring Md</u>	
17. INFORMANT <u>Clarence Wright - R-2 Silver Spring Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO (b) <u>shot gun wound in chest (heart)</u> DUE TO (c) <u>sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year <u>1-1 1958</u>	
20c. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>home</u>		20d. (City or town) (County) (State) <u>Takoma Park Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>1-1-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 4, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Hall</u>		24a. RECEIVED BY REGISTRAR <u>U. S. H. H. H. H.</u>	
24b. REGISTRAR'S SIGNATURE <u>U. S. H. H. H. H.</u>		24c. ADDRESS <u>12, D.C.</u>	

U. S. A.

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989

CERTIFICATE OF DEATH

Reg. Dist. No. 00983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Clinton</u> 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMC, Bethesda Md.</u>		d. STREET ADDRESS <u>365 Woodyard Rd., Route #2</u> None	
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>(nmn)</u> Last <u>ZAVITSKI</u>		4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 January 1958</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Keith Stephen ZAVITSKI</u>		14. MOTHER'S MAIDEN NAME <u>Donna Marie McNAMARA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>(Father) Keith Stephen ZAVITSKI (Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyaline Membrane Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>23 January, 19 58</u> , to <u>24 January, 19 58</u> , that I last saw the deceased alive on <u>24 January, 19 58</u> , and that death occurred at <u>11:55A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda Md. 1-24-58</u>			
ACTUAL SIGNATURE <u>Adam G. Thorp Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Adam G. Thorp, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Clinton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphery</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Adam G. Thorp Jr.</u>			

205/202 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

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JAN 27 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

844

CERTIFICATE OF DEATH

Reg. Dist. No.

00984

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>1008 Quebec Tr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wanda</u> Middle <u>Lee</u> Last <u>Zembower</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 3, 1932</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Norman Ray VanMeter</u>				14. MOTHER'S MAIDEN NAME <u>Belva Cruthers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Patient's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>648.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shock</u> (c) <u>Ruptured uterus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>6 hrs.</u> <u>6 1/2 + hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pregnancy, full term, delivery</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1 March 1957</u> to <u>11 Jan 1958</u> , that I last saw the deceased alive on <u>11 Jan 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles R. Hughes</u>				ADDRESS (Street, city or town, state) <u>8226 Trenton St., Silver Spring</u>			
DATE SIGNED <u> </u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u>				ADDRESS <u>Silver Spring Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

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